California Association of
Public Hospitals and Health Systems

January 14, 2012

Mr. Peter Lee
Executive Director, California Health Benefit Exchange
560 J St., Suite 290
Sacramento, CA 95814

Subject: Response to Covered California's "Bridge Plan: A Strategy to Promote Continuity of Care and Affordability through Contracts with Medi-Cal Managed Care Plans"

Dear Mr. Lee,

The California Association of Public Hospitals and Health Systems (CAPH) appreciates the opportunity to submit comments regarding Covered California's Bridge Proposal that seek to address issues related to affordability, continuity of care, and safety net provider participation in Covered California.

As public hospital systems prepare for health reform implementation, they anticipate filling multiple roles in their communities: as major safety net providers for the remaining uninsured and other vulnerable populations; as competitive providers of choice for the newly covered through Medi-Cal and Covered California offerings; and as providers of essential community services, including trauma, burn and training.

Keenly aware of the policy issues that may impact public hospital systems ability to serve these multiple roles, we are especially focused on policies that seek to:

1. Help ensure that low-income individuals and families can afford coverage and minimize the remaining number of uninsured;
2. Help ensure seamlessness of coverage and continuity of care for low-income and vulnerable populations; and
3. Strengthen California's traditional and safety net provider network to ensure its continued and necessary viability.

As longstanding supporters of the Basic Health Plan, we continue to believe these goals are essential to the success of health reform in California and appreciate the work by Covered California staff in developing and refining strategies to address these critical issues. In response to the recent Bridge Plan, CAPH respectfully submits the following questions, concerns and recommendations.

Ensure Participation of Medi-Cal Managed Care Plans

CAPH applauds Covered California for recognizing the value of Local Medi-Cal managed care plans and appreciates your efforts to address current barriers to their participation. Local Medi-Cal managed care plans serve the largest number of Medi-Cal beneficiaries; have extensive experience serving their local communities; and contract in a meaningful manner with California's traditional safety net providers. Their participation in Covered California will be critical in helping to ensure continuity of care for low-income individuals who transition between Medi-Cal and Covered California; supporting the inclusion of traditional

safety net providers; and offering an additional choice for consumers, including low-income families that may already be familiar with such local plans.

As Covered California continues to explore the Bridge Plan option, CAPH recommends that additional provisions be included to further support the goals outlined in the proposal and to ensure Local health plan and safety net provider participation.

1. Require a stronger ECP definition and QHP requirements for any plan designated as Bridge plan

The Bridge Plan includes a number of recommendations to address barriers to participation for Medi-Cal managed care plans, a goal we fully support. However, given that the goals of the Bridge plan are to ensure continuity of care for populations transitioning between Medi-Cal and the Exchange and support safety net providers that currently serve this population, the requirement for defining and contracting with Essential Community Providers (ECPs) must be strengthened. We do not support the recommendation to "deem Medi-Cal managed care plans to have satisfied the Essential Community Provider network by virtue of the composition of their typical networks". When Medi-Cal managed care plans were created, local Medi-Cal managed care plans were required to work with traditional safety net providers, commercial plans were encouraged but not required. As a result, public hospital inpatient utilization in most provider counties is generally three to five times higher with the Local Medi-Cal managed care plans; on the outpatient side, utilization of public hospital systems is roughly four to five times higher through the local plans when compared to their commercial plan competitors. Since the requirement to contract with safety net providers only applies to some Medi-Cal managed care plans, we believe the ECP requirement should not be removed and in fact should be strengthened for all Bridge plans.

We agree with the statement in the Bridge Plan proposal that "avoiding disruptions in provider networks and continuity of care is also of critical importance to consumers". The best way to ensure continuity of care is achieved is by requiring that the traditional safety net providers who serve the most uninsured and Medi-Cal patients are included in Covered California-based networks for low-income members. Specifically, we recommend that for any plan that is designated as the Bridge Plan or the lowest cost silver plan, a more stringent definition of ECP should be applied, to ensure that the traditional safety net providers who serve the largest number of uninsured and Medi-Cal enrollees are included in the plans network. For this narrower definition, in addition to the criteria for ECPs already approved by the Covered California Board, we recommend that providers must also demonstrate that at least 50% of their costs are associated with providing care for Medi-Cal and uninsured patients, with a minimum of 10% of their costs comprised of uninsured costs.

Furthermore, Medi-Cal managed care plans designated as the Bridge option must also be required to contract with a greater number of traditional safety net providers. Therefore, to help promote continuity of care for low-income populations, we recommend that the Bridge Plan/ lowest cost silver plan must also contract with at least 35% of these more narrowly defined ECPs within each of the plans geographical area. Additionally, we recommend that Covered California implement measures to continually monitor and evaluate whether the lowest cost silver plan is contracting with a sufficient number of the more narrowly defined ECPs in a meaningful manner. For example, in order for an ECP contract to count toward meeting the 35% threshold, lowest cost silver or Bridge plan should be required to contract for the full scope of services offered by such ECP providers. For example, if a commercial HMO plan contracts with a public hospital system for a limited number of specialty services, or the contract is limited to trauma services but does not allow any patients to select that hospital for primary care services (i.e. their medial home), that contract should not count toward meeting the 35% threshold.

2. Continue to address barriers to Local Health Plan participation

Given that some of the current QHP participation requirements will be very difficult for local Medi-Cal managed care plans to meet, we appreciate Covered California's efforts to address these issues by further streamlining approaches for QHP certification for Medi-Cal managed care plans, combined with the already approved extension of the timeline for obtaining full NCQA accreditation. However, other QHP qualification requirements may prove difficult for many of the Local and COHS plans to meet for several more years. Therefore we recommend that Covered California continue to work with local health plans and safety net providers to identify what additional flexibility will be needed to ensure active participation as a Bridge Plan.

3. Establish basic standards for all Bridge Plans

In addition to the ECP contract requirements recommended above, health plans designated as the Bridge Plan should be required to maintain some basic standards for the provision of care to enrollees. In promoting the goals of affordability, a basic set of standards should be in place to prevent a "race to the bottom" from health plans that may compromise other key Covered California goals in an effort to offer the lowest cost products. Such standards should include quality measures, sufficiency of payment rates to providers, cultural competency, language access, etc.

Maintain Long Term Affordability and the Sustainability of an Enhanced Subsidy

Under both the previous affordable option presented by Exchange staff in December 2012 and the current bridge proposal, greater affordability for low-income consumers can only be achieved if there is at least a modest differential in the cost between the second lowest and lowest cost Silver Level Benefit Plans. Since an individual's federal subsidy is based on both their income and the cost of the second lowest cost plan, individuals who purchase the lowest cost plan (assuming at least a moderate gap in the cost of plans exists) will benefit from a lower premium and lower out of pocket costs.

However, for this approach to work, such a gap in premiums must remain in place over time and must be substantial enough in order to ensure that low-income individuals can benefit from greater affordability offered by the lowest cost plan and purchase coverage through Covered California. Given that premiums are not fixed and could fluctuate from a competitive bidding process among QHPs, there is no guarantee that another plan will not offer a premium at or near the same price point of the lowest cost plan. Consequently, two plans at or near the same cost would thereby negate the cost differential and eliminate the greater affordability option Covered California was seeking via the Bridge Plan. Such a likely scenario could jeopardize the goal of increased affordability this option seeks to achieve. How is Covered California going to ensure that this premium differential remains intact over time?

Clarify Process for Obtaining State and Federal Approval

We greatly appreciate the thoughtfulness demonstrated in the Bridge Plan to improve affordability, continuity of care, and safety net participation. However, we anticipate some of the proposed recommendations will likely require further guidance from CMS, as they are outside of the prescribed Covered California structure as set forth in the various federal health reform laws and regulations. How quickly does California Covered believe that this guidance can be given so that the proposed Bridge option

could be implemented by January 1, 2014? Can Covered California proceed with both Recommendations 1 and 2 simultaneously while working to secure federal approval? Additionally, what state legislation will be required to implement the Bridge proposal recommendations?

Thank you for the opportunity to submit our comments. We look forward to continuing to identify ways to be supportive of the Exchanges mission to maximize enrollment and improve health for all Californians.

Sincerely,

Melissa Stafford Jones
President & CEO