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January 14, 2013

Mr. Peter Lee

Executive Director

California Health Benefit Exchange

560 J St., Suite 290

Sacramento, CA 95814

S SUBJECT: Covered California Bridge Plan Recommendations

Dear Peter:

On behalf of the California Children's Hospital Association, we appreciate the opportunity to comment on the January 10, 2013 *Covered California Bridge Plan: Continuity of Care & Affordability Board Recommendation Brief*.

We are generally in support of the concept of the Covered California Bridge Plan. Our concerns center on the following issues:

- Health Plans should not be permitted to impose the markedly inadequate MediCal rates on hospitals for Bridge enrollees.

- CCHA believes that providers should be permitted to negotiate rates to ensure adequate, fair and timely payment policies for all providers and address provider shortages and access issues, particularly for children in need of specialty services.

- We harbor serious concerns about what may be an overreliance on the chassis of MediCal Managed Care Plans for solving a multiplicity of policy issues. While we applaud the commitment of these Plans, we have concerns that layering on financial and administrative responsibilities without appropriate upfront vetting of capacity and strong solvency oversight sets the stage for network gaps and failures.

- There must be parameters around relaxed regulatory provisions. The strong DMHC oversight on network adequacy, claims payment and financial solvency was fashioned after fundamental system failures in the late 1990s that gave 'managed care' a very bad reputation, which perception persists despite strong consumer protections.

Why does reimbursement rate profoundly impact CCHA hospitals? Children's Hospitals are highly dependent on MediCal. On average, MediCal is the payer for more than 50% of all Children's Hospitals' patients and California has one of the very lowest reimbursement rates in the entire United States. Our dependence on MediCal renders our institutions highly vulnerable

to policy changes in the non-MediCal environment that potentially reduce other payer's rates below full cost reimbursement.

California's eight Children's Hospitals provide the most intensive levels of pediatric care in the State -- over 57% of the state's Pediatric Intensive Care Unit (PICU) beds are in children's hospitals. We treat children with serious and life-threatening diseases like leukemia and other cancers; heart problems; sickle cell anemia; diabetes; HIV and cystic fibrosis. Our hospitals are the nation's premier pediatric research facilities and are important training centers for sub-specialists and other pediatric healthcare professionals, providing graduate medical training for more than 650 full-time residents, of whom more than 300 are in pediatric subspecialties.

Our hospitals are Essential Community Providers and, like other ECPs, because of their commitment and geographic location, will most likely serve a preponderance of Covered California enrollees that are within the Bridge Plan populations. If commercial-like rates do not materialize for the Covered California population, including those under the Bridge Plan proposal, and our hospitals as Essential Community Providers are paid Medicaid-like rates instead, California's Children's Hospitals are greatly threatened.

Our cost structures are simply higher, for good reasons. Physicians tend to refer the sickest children, whose treatments are complex and expensive, to Children's Hospitals. Our average case-mix (which measures resource intensity) is about 25 percent higher than that of other hospitals that treat pediatrics. Complex surgical cases can cost five to six times more per day than an average case at a community hospital. Children's Hospitals cannot sustain additional inadequate rates and continue to provide high-quality critical care to children in need.

Why should Plans have to negotiate to compose their provider networks? Children's Hospitals, and all hospitals, should not be forced to participate in networks without the opportunity to bargain. Of particular concern to our hospitals is the concept of providing bargaining supremacy to plans because "establishing a provider network and negotiating rates to the extent the plan does not use existing Medi-Cal contracts and needs to negotiate different terms".

Covered California is not MediCal and giving health plans serving the Bridge population monopolistic bargaining power is a short-term tactic, and not a sustainable strategy. Imposing rates and that reimburse our hospitals below the costs of providing care and contract terms conditions that are one-sided will perhaps work for a year or two but will eventually collapse the safety net structure.

Why should Plan oversight not be scaled back excessively. CCHA support streamlining inapplicable, duplicative, gratuitous administrative red-tape for Bridge plans and all QHPs. However, timely access to care, as cultivated by robust adequate networks, including strong specialty networks, is a fundamental right and expectation for California managed care consumers. Consumers must have access to adequate networks as deemed by the appropriate regulatory body. Bridge plans must not be exempt from adhering to network adequacy requirements.

Further, strong financial oversight must continue to be assured of MediCal Managed Care plans being 'repurposed' for broader policy responsibilities under Covered

California. Financial oversight ensures that providers are being properly paid, which ensures that they can keep their doors open, which ensures that patients have continuity of care.

Thank you for the opportunity to share our comments and concerns. As always, these comments reflect our utmost respect for the difficult tasks and policy choices you face.

Best regards,

Cindy Ehnes

President and CEO