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On behalf of Dignity Health and our 33 California hospitals, we appreciate the opportunity to comment on the January 10, 2013 *Covered California Bridge Plan: Continuity of Care & Affordability Board Recommendation Brief*.

Dignity Health plays a central role in California's private safety net. In fact, we are the largest private provider of Medi-Cal services in California. As such, Dignity Health provides between 9-10 percent of Medi-Cal's total hospital-based services. In a typical county in which we operate, we represent between 15-20 percent of Medi-Cal services. Last year alone, Dignity Health:

- Provided more than 530,000 in-patient days for Medi-Cal beneficiaries;
- Delivered more than 1 million outpatient visits to Medi-Cal beneficiaries; and
- Represented 12 percent of all Medi-Cal inpatient discharges.

Dignity Health's commitment to Medi-Cal is only one part of how we serve vulnerable populations. Dignity Health also provides significant amounts of charity care and uncompensated care. In California in fiscal year 2012, Dignity Health:

- Provided $141 million in charity care services (at cost);
- Absorbed a Medi-Cal shortfall of $402 million (from cost after provider fee);
- Absorbed a Medicare shortfall of $415 million (from cost); and
- Provided total Community Benefit of $1.1 billion in California.

We have been proud to partner with the State of California serving Medi-Cal beneficiaries, the uninsured and underinsured. **We deeply care about the continuity of care for this population, but want to strongly caution Covered California about making assumptions that traditional providers will be in a position financially and/or be in a position to provide sufficient capacity in the short-term and/or long-term, to take on another population of most-likely "under-funded" patients.**

Dignity Health strongly supports Covered California's goals of ensuring greater affordability and accessibility of health insurance, reducing churn and ensuring continuity of care, while also

supporting a strong safety net of providers that will continue to serve more than 3 million uninsured Californians after the Affordable Care Act is implemented.

We appreciate that Covered California must move quickly in order to implement any proposal to increase affordability and continuity of care, but we are concerned about the lack of time to think through and implement this proposal. Based on the information that was provided to the Covered California Board and the current status of the Qualified Health Plan (QHP) solicitation process, it appears that Covered California may not have sufficient time to receive federal approval and effectively execute this proposal by 2014. **We request that Covered California clarify the implementation steps and timeline.** In particular, as a provider, Dignity Health is challenged by the Bridge Plan proposal being "up in the air," while payers and providers are preparing for the payers' proposals due to Covered California between now and the end of March. The outcome of the Bridge Plan approach will affect providers' proposals to payers and payers' proposals to Covered California.

Dignity Health has the following concerns and questions about the recommendations being considered in the January 10, 2013 brief:

Covered California Recommendation 1: Covered California Should Contract with Bridge Plans for Transitional Medi-Cal Eligibles and Parents of Medi-Cal/CHIP Children

Dignity Health sees the benefit in Covered California contracting with payer that offer both Medi-Cal Managed Care Plans and Individual Commercial Insurance as "Individual Bridge Plans," which are intended by the federal government to promote continuity of coverage between Medicaid or CHIP and the Exchange by providing those beneficiaries with access to their existing providers.

Dignity Health can support the concept of a Bridge Plan under the following guidelines/terms:

1. Bridge plan payers must be required to negotiate contracts with providers (physicians, hospitals, others) at competitive reimbursement rates for this new population; assuming plans can just "expand/extend" Medi-Cal managed care contracts and rates with their existing provider network is not a viable option for providers.

2. Plans must be required to demonstrate adequate provider networks to ensure access to care, not just insurance coverage.

3. Beneficiaries should only be allowed to stay actively enrolled in a Bridge Plan for 18 months (with no churning back to Medi-Cal). Following 18 months of active enrollment in a Bridge Plan, beneficiaries should be eligible for a brief open enrollment period and should be required to transition into a commercial plan within (or outside) the exchange.

4. Covered California should push back on the Federal Government guidance that disallows the exclusion of the Bridge Plan rates when calculating the lowest and second-lowest silver plans in the rating region. Inclusion of the Bridge Plans in the calculation of the lowest and second-lowest plans will prohibit people who do not qualify for the Bridge Plan from access

to insurance coverage intended by the Affordable Care Act. The ACA is will provide Federal subsidies for insurance premiums based upon the premium level of the second-lowest priced Silver product in the Rating Region. This should allow all people with incomes in the 139% - 200% of the FPL to choose between the two lowest priced Silver Plans in their Rating Region, while limiting their premium cost (net of Federal tax credits) to 3% - 9.5% of income. The likely unintended consequence of the Federal Government guidance would be to materially limit access to insurance for people who do not qualify for the Bridge Plan.

5. The Bridge Plan design and implementation should not disadvantage traditional safety net providers; it needs to create a level playing field among plans as a group and among providers as their own group. We encourage Covered California to consider its priority of improving access to health care in the short term and long term; this will require all Californians be afforded access to high quality, reasonably priced health care insurance and provider costs. This will also require the vast majority of the current provider network be viable which can only be created through level playing fields.

The January 10, 2013 Bridge Plan brief indicates that Bridge Plan rates may be as high as 103-115 percent of Medicare rates. Dignity Health requests further clarification about how these estimates were established. Additionally, when Covered California considers health plan administrative fees between 6 and 15 percent, there will not be adequate funding available to sustain the long-term viability of providers. **Even with current DSH reimbursement levels, 115 percent of Medicare does not currently cover the weighted average cost of care in our California hospitals. Our current and projected financial situation does not allow us to take on an additional significant population of patients that does not cover our costs.**

Dignity Health strongly urges Covered California to consider all of the moving payment parts included in the ACA when it looks at the reimbursement rates that providers will receive. We are not asking Covered California to set rates for the Bridge Plans or to intercede in contracting issues in any way, but rather to understand that in a new day, providers will need to contract with existing and new payers in new ways. A couple of these existing moving payment reforms are the Medicare and Medicaid DSH reductions called for under the ACA, beginning in 2014. Unless the reductions percentages are changed by the federal government, Dignity Health will stand to lose nearly $175 million dollars annually in DSH funding under the premise that more patients will be insured and providers will receive commercial-like rates – not rates that approximate Medicare or Medi-Cal current rates.

Covered California Recommendation 2: Bridge Plans Should Cover 138% to 200% of FPL Eligible Population

Without additional details and clarification on this recommendation, Dignity Health cannot support this broad bridge to reform. Based on our above comments on recommendation one, this broader bridge would only further complicate the process of negotiating/contracting with plans and network adequacy.

This population should be carefully considered and protected as Covered California moves forward, but Dignity Health believes additional work on how to achieve this policy objective is needed. The approach outlined potentially disadvantages traditional safety net providers and does not appear to create a level playing field among plans or providers.

Recommendation 3: Streamlining Approaches for QHP Certification for Medi-Cal Managed Care Plans & Bridge Plans

Dignity Health understands the desire to streamline the QHP solicitation process to allow all Medi-Cal Managed Care Plans an equal opportunity to respond only to elements of the solicitation that are applicable to a non-commercial health plan.

Dignity Health does not support the staff recommendation to "Deem Medi-Cal Managed Care Plans to have satisfied the essential community provider network requirements by virtue of the composition of their typical networks," (page 8). Since we strongly support new contracts between Bridge Plans and providers, it would require plans to demonstrate they have contracted network compositions accessible to Bridge Plan members.

Additional Concerns/Considerations

While Covered California may be able to quickly address the above concerns, we believe the Governor's January 10, 2013 budget, which proposes exploring both a state-based ACA Medicaid expansion option and an alternative county-based Medicaid expansion option to manage the newly-eligible Medi-Cal population, requires thoughtful consideration before Covered California finalizes any Bridge Plan proposals. An effective crosswalk can only be created if we understand the Medi-Cal side of the equation for the ACA expansion.

Thank you very much for your consideration of our comments and recommendations. Dignity Health looks forward to continuing to work with Covered California as it determines how to best maximize affordability, access and continuity of care in the exchange.

If we can provide further clarification or information, please don't hesitate to contact me at 916/837-3208 or via email shelly.schlenker@dignityhealth.org.

Sincerely,

Shelly L. Schlenker

Shelly Schlenker
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