March 24, 2016

Commissioner Dave Jones
California Department of Insurance
300 Capitol Mall, Suite 1700
Sacramento, CA 95814
Submitted to Kayte.Fisher@insurance.ca.gov.

Re: Anthem/Cigna Merger

Dear Commissioner Jones:

Thank you for the opportunity to comment on the proposed acquisition of Cigna by Anthem. The California Primary Care Association (CPCA) represents more than 1,100 nonprofit community clinics and health centers (CCHC) in California that provide comprehensive quality health care services to low-income, uninsured, and underserved Californians. CPCA members include Federally Qualified Health Centers (FQHCs) and other licensed community and free clinics throughout the state. One in seven Californians are served by CCHCs, translating into an annual patient base of approximately 5.7 million. In fact, an independent report released in December 2015 shows that California health centers are at the center of ensuring access for both public and commercial Med-Cal managed care plans, absorbing fully 54% of new members entering both public and commercial plans since the expansions of the ACA.[1] Both public and commercial programs' reliance on CCHCs has grown significantly, and these critical access points require continuing and increasing levels of investment to expand capacity and improve care. CCHCs and our low-income patients are some of the most severely impacted by changes to the delivery system which could lead to higher premiums or reductions in access, especially in the subsidized insurance markets.

CPCA writes today to ask the Department to evaluate this proposed transaction by asking how the health care delivery system will be helped or harmed by this merger. While the efficiencies of consolidation should be applauded when they result in better care and a healthier population, transactions motivated by a plan's business interests may not always be good for health plan enrollees or the California delivery system. Health plan mergers may lead to less choice, higher premiums, and decreases in provider compensation but that result is not inevitable. Through carefully crafted undertakings, the Department has the ability to

[1] California HealthCare Foundation, "Medi-Cal Managed Care Plans and Safety-Net Clinics Under the ACA." December 2015. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalMgdCarePlansSafetyNet.pdf. Accessed December 14, 2015.

circumvent many of the negative outcomes and even incentivize investment in programs that address some of California's health delivery system's greatest needs: an investment in workforce, IT and data infrastructure for care delivery and coordination, and value based care delivery transformations. Without concerted and deliberate investment in all three of these areas our delivery system will not achieve the larger aims of the Affordable Care Act.

1. **Improving Networks and Addressing the Workforce Shortage**

Payors, providers, and patients are collectively impacted by a chronic and severe shortage of primary care Medi-Cal providers in California. In fact, we believe that developing a strong health care workforce in California is the greatest need and highest priority for any investment that might come of this merger. The attached report, "Horizon 2030: Meeting California's Primary Care Workforce Needs," was commissioned by CPCA and authored by respected health workforce researchers Jeff Oxendine, who is an Associate Dean for Public Health at the UC Berkley School of Public Health, and Kevin Barnett, a Senior Investigator at the Public Health Institute. The report's name comes from a striking statistic included within the report: "At current utilization, California will need an estimated 8,243 additional primary care physicians by 2030, or 32% of its current workforce (Pettersone, Cai, Moore, & Bazemonre, 2013)." The report also notes that California's ratio of primary care physicians participating in Medi-Cal is approximately half of the federal recommendation.

Without an adequate number of providers, value based transformation efforts will be futile. ***As a first step to growing the Medi-Cal network and improving access to care, we strongly recommend that the Department require the surviving corporation to make a substantial investment in California's health care workforce.*** CPCA would especially prioritize the following workforce investment opportunities:

- State Loan Repayment Grants: California currently offers, through the Office of Statewide Health Planning and Development (OSHPD), the California State Loan Repayment Program (SLRP), which provides educational loan repayment assistance to primary health care professionals who provide health care services in federally designated Health Professional Shortage Areas (HPSAs). Eligible health professionals include physicians specializing in primary care fields, nurse practitioners, certified nurse-midwives, general practice dentists, registered dental hygienists, clinical or counseling psychologists, clinical social workers, licensed counselors, pharmacists, physician assistants, psychiatric nurse specialists, and marriage and family therapists. The SLRP requires that eligible health professionals must be employed by or have accepted employment at a SLRP certified eligible site (which includes rural health clinics, community health clinics, county facilities, and federally qualified health centers) and must commit to providing full-time or half-time primary care services in a HPSA for a minimum of two years. Health professionals may receive up to $50,000 in exchange for a two year full-time service obligation and/or $25,000 for a two year half-time service obligation; individuals can apply for service extension, which can increase the total loan forgiveness amount to $110,000 over six

years at full-time and $80,000 for half-time service. SLRP award amounts are matched by the site(s) in which the health professional is practicing, on a dollar-for-dollar basis, in addition to salary. The SLRP is funded through a grant from the HRSA, Bureau of Clinician Recruitment and Service, National Health Service Corps (NHSC) and is administered by OSHPD.

The Association of American Medical Colleges' most recent data identifies that the cost of attending a 4-year medical school at a public university at approximately $220,000, and $290,000 at a private university. As the discussion to increase funding to the SLRP continues, some have argued that the award amounts currently offered are not a significant enough incentive for health professionals with substantial debt to serve in HSPAs. ***To address some of that concern, we recommend the Department consider requiring an undertaking which allocates resources to complement the SLRP program by offering a standalone loan forgiveness program designed to begin when the SRLP award expires.*** This structure would ensure the provider will remain at a site in an HSPA for a longer period than required under the SLRP requirements.

Additionally, the Department might consider allocating funding to establish a trust fund for provider loan repayment, structured to last into perpetuity. An example could be allocating $50 million to a trust fund, assuming a 1.5% rate of return on a 5-year treasury bond could net, based on simple interest, approximately $1.5 million every three years into perpetuity. While initially this model will serve fewer providers, it creates a program that converts a one-time allocation into an ongoing program with a funding source. ***To ensure that the undertakings required of this merger continue to serve low income communities into the future, we recommend that the Department also require the surviving corporation to establish a trust fund for provider loan repayment.***

We are hopeful that these in the areas of recruitment and retention will be a model for the industry and could lead to new industry-level cooperation. The loan repayment programs undertaken as a part of this merger could serve the state as a launching point for new public and private investments in loan repayment and scholarship programs.

- Teaching Health Center Residency: Health centers continue to explore ways to develop community-based residency training programs that encourage providers to train and work in underserved communities. One successful program launched through the ACA was the Teaching Health Center program- a program that funds CCHCs to house primary care residency programs. Because residents are most likely to stay in the area where they conduct their residency, the Teaching Health Center program is extremely powerful in securing primary care providers for underserved communities. A significant challenge to expanding the number of programs, however, is the lack of dedicated funding, both for

the creation of new residency programs and the expansion and support of existing programs.

Today, funding for teaching health centers comes from the federal government and is set to expire in 2017 – it will not last the length of a full residency period for the current class of residents who began in 2015. Federal funding for the existing Teaching Health Center program was reduced by approximately 35% this year, from $150,000 per resident to $95,000 per resident. The gap in funding must be made up by the health centers individually. This is an enormous challenge because having a residency program, even if the residents are fully funded, are a significant cost to the health center, and filling the above referenced funding gap costs safety-net clinics more than $50,000 per resident, per year. This funding instability creates an enormous barrier to FQHC participation in the program and has reduced the number of primary care residents that might otherwise be trained to serve California's low-income communities. ***To combat this challenge, we recommend that the Department require an undertaking that invests in a grant program to cover the currently-unfunded costs of training residents through a teaching health center. Grant allocations would be awarded on a per-student-basis, ensuring that the funding for teaching health center residencies is comparable to the funding at teaching hospital residencies.***

In addition, the Department might consider an undertaking that creates a grant program to support new Teaching Health Center residency programs that are specifically geared toward producing providers dedicated to serving California's rural and urban underserved communities. For example, a grant program could be established that would help a health center in a low income, underserved area cover the cost of establishing or expanding a primary care residency program, including costs associated with curriculum development, recruitment, training, and retention of residents and faculty, accreditation by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA), faculty salaries during the development phase, and technical assistance. ***One of the most meaningful investments that the Department could require of this merger would be to allocate funding for a statewide teaching health center grant program, both to support the cost of residents and to support the creation of new teaching health center residency programs.***

2. **Investment in Care Coordination Infrastructure for Safety-Net Providers**

A foundational element necessary for care transformation is the creation of an IT infrastructure that allows for data-sharing across the various parts of the delivery system. We have listed below some options for investment in health IT that would serve as a foundation to better care coordination, higher quality care, and improved health outcomes.

- Data Sharing Across the Delivery System: ***We request that the Department require the surviving health plan to ensure that contracted providers have access to the data necessary to coordinate care for their patients.*** Two essential pieces of data include membership lists and hospital admit/discharge/transfer data. Membership lists should be shared at least monthly and hospital data in real time. These are critical first steps to care coordination and are absolutely necessary for CCHCs to deliver the type of comprehensive, whole-person care we are mission-driven to provide.

- Support for Telehealth Programs: Telehealth is increasingly used as a model to deliver health care services in a patient focused way, especially in rural communities, because it reduces the burden on patients to drive long distances or experience long delays. Many health centers are interested in going further with telehealth but are challenged by the costs of managing a dedicated telehealth program. Many health centers are forced to subsidize the cost of the specialty care they are linking the patient to, on top of the costs of the equipment and staff. ***Health plans should be required to pay for the specialty services, and provide technical support to health centers interested in using telehealth to delivery specialty care. Technical support would include providing and supporting the technology, finding the specialists, and scheduling with the specialists.***

- Grants to Purchase Data Analytics Tools: While CCHCs have almost universally implemented Electronic Health Records (EHR), they often do not have the data analytics technology that enables a higher level of care coordination and patient assessment/targeting. ***We recommend that funding from the merger be set aside to issue grants to purchase vendor-agnostic data analytics tools to sit atop EHRs as well as technical assistance from the health plan on how to analyze and vet the data.***

- Bandwidth Expansion Program Match Grant: Purchasing the requisite amount of broadband bandwidth is challenging for all safety-net providers, especially those in rural areas because costs can be higher. In 2013, the Federal Communications Commission (FCC) recommended a minimum bandwidth speed of 10Mbps for rural CCHCs but most do not meet this minimum speed today. In California, the California Telehealth Network (CTN), funded through the FCC Rural Health Care Pilot Program, is California's authorized FCC broadband consortia to address the "connectivity gap" for California healthcare providers. Eligible sites receive sixty-five percent assistance from the FCC, but are required to provide the additional thirty-five percent match. ***The Department should set funding aside to provide the thirty-five percent match to safety-net providers seeking greater connectivity.***

3. Value Based Care Transformations

A major component of the Affordable Care Act was to change the way that we pay for care, moving away from a reimbursement model that rewards utilization to one that rewards quality and outcomes. No longer should health care be about how many patients can be seen, how

many tests and procedures can be done, or how much can be charged for these services. Instead, we have the opportunity to move the health care system to look at costs and patient outcomes. We believe that the most successful total cost of care reduction programs are those that continuously move providers along the path to quality and from volume to value with a focus on performance improvement and shared savings. In fact, CPCA member health centers have already embarked on the journey to value-based payment. Last year, Governor Jerry Brown signed Senate Bill 147 (Hernandez) into law. The bill, which was sponsored by CPCA and highlighted as a Horizon 2030 priority recommendation, authorizes a three-year demonstration project which provides Federally Qualified Health Centers operational and reimbursement flexibility to use new team-based primary care models.

Under the demonstration, selected FQHCs will participate in an alternative payment methodology (APM), and will move from the current volume-based fee for service FQHC payment system to primary care capitation. Participating FQHCs are beginning a challenging transition process to transform the way they deliver care and are investing heavily in value-based payment reform. ***We hope that the Department, as a condition of approval, will require that the surviving health plan invest heavily in value based care transformation through engaging with providers in the creation of new systems and processes that facilitate the sharing of data, member information, and care coordination activities, as well as robust quality/shared savings incentive programs to ensure that patients throughout the entire delivery system benefit from improved care, better outcomes, and lower costs.***

Thank you for the opportunity to provide our suggestions. If you have questions or comments please contact Meaghan McCamman at mmccamman@cpca.org.

Sincerely,

Carmela Castellano-Garcia
President and CEO
California Primary Care Association