A" Natividad
MEDICAL CENTER

August 3, 2012

California Health Benefits Exchange
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Submit via email: infO@hbex.ca.gov

Dear HBEX Board and Staff:

On behalf of Natividad Medical Center (NMC) and our patients, I am writing to provide input on your proposed recommendations for Qualified Health Plans (QHPs) in the Exchange. Natividad Medical Center appreciates the opportunity to provide input into the planning and development of the policies and structures of the Exchange, as they will have a profound impact on the health care financing and delivery system in California for years to come.

NMC is a 172-bed acute care hospital owned and operated by Monterey County. As a successful designated public safety net provider serving the residents of Monterey County for over 126 years, NMC provides health care access to all patients regardless of their ability to pay. Currently, over 66% of NMC's patient population is covered by Medi-Cal, the Medically Indigent Adult Program, or is uninsured. NMC offers inpatient, outpatient, emergency, diagnostic and specialty medical care. With an annual operating budget of $175M, NMC provides more than 34,000 patient days each year and more than 44,000 emergency department visits per year. NMC is ranked #1 in newborn deliveries in Monterey County. The hospital operates with a medical staff of over 235 physicians and has several specialty clinics and outpatient primary care clinics operated by the Monterey County Health Department. NMC is the only teaching hospital on the Central Coast, through its affiliation with the University of California, San Francisco (UCSF).

Essential Community Provider

As a traditional safety net provider that has served low-income, Medi-Cal and uninsured patients, we believe it is especially important to inform you of our concerns regarding the proposed definition of "Essential Community Providers" (ECPs.) The requirement that QHPs include ECPs in their networks offers a tremendous opportunity for the Exchange to help support three critical goals that will impact the entire health care system:

1. Ensuring continuity of care for patients
2. Providing access to care to providers who have cultural and linguistic expertise, and a deep knowledge of the complexities of low-income patients; and
3. Supporting and strengthening the health care safety net upon which we all depend.

These goals are all imp01tant and none must be sacrificed in the service of another. For these reasons, we support the approach recommended by the California Association of Public Hospitals and Health Systems (CAPH), which has offered a potential "middle ground" between a narrow definition that may miss some providers who serve dispropo1tionate numbers of Medi-Cal and uninsured, and a broad approach which, in taking all comers, fails to

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adequately differentiate providers that serve a patient population that is disproportionately low-income, medically underserved and uninsured.

Specifically, CAPH has proposed the following definition for an Essential Community Provider:

(a) **Essential Community Provider ("ECP")** means safety net providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. The following organizations qualify as an ECP: (i) "qualified hospitals," (ii), "qualified clinics" or (iii) other safety net providers that (x) have a mission or mandate to deliver services to persons who experience barriers to accessing care and (y) provides a "substantial" volume of care to persons who are uninsured or who are enrolled in Medi-Cal.

(b) **"Qualified Hospitals"** as set f01th in section (ii) above shall include those hospitals designated by the Department of Health Care Services as a disprop01tionate share hospital, children's hospital or designated public hospital system and its affiliated clinics.

(c) **"Qualified Clinics"** as set forth in section (iii) above shall include:

- Community Clinic or Health Center: Licensed as either a "community clinic" or "free clinic" by the State under California Health & Safety Code§1204(a) (I) and (2), or is exempt from licensure under Section 1206.

- FQHC: An entity that is recognized as a Federally Qualified Health Center under Section 1861(aa)(4) or 1905(1)(2)(8) of the Social Security Act (42 U.S.C. §§1395x(aa)(4), 1396d(l)(2)(B)).

- IHC: Indian health clinics are federally designated as 638 Tribal Health Programs and Title V Urban Indian Health Programs.

- SBHC: A school-based health center as is defined in the Children's Health Insurance Program Reauthorization Act/Social Security Act (2009), Public Law 74-271, Sec 211O(c)(9).

(d) **"Substantial'"** as set fotth in section (a)(iii) above shall mean that no less than 50% of all costs associated with providing care is for Medi-Cal and uninsured patients where a minimum of I0% is comprised of uninsured costs.

(e) Provider shall self-certify as to meeting this requirement on an annual basis. Such certification is subject to audit by the Exchange on an annual basis, and if it is determined that such provider does not meet the definition of ECP, such provider shall be precluded from meeting the definition of ECP for at least three years following such audit results.

This proposed definition supp01ts the suggested approach of offering distinct definitions of ECPs for hospitals and outpatient settings. If the Exchange adopts a different definition than the one offered above, we strongly recommend that the definition recognize the comprehensive nature of our public hospital system by including our inpatient services in the hospital definition, and our outpatient clinics in the non-hospital definition. Futthermore, the definition must also require providers to atticulate the role they play in providing care to not only California's Medi-Cal but also the state's uninsured population.

Finally, in order to ensure adequate access to ECP's within each Qualified Health Plan network, we support the Exchange staff s recommendation to establish a geographic approach as the best strategy to ensure all regions throughout the state meet sufficient ECP access standards.

Building on to the Exchange's approach, we also support CAPH's recommendation that the Exchange require a ce1tain threshold for all QHP's in order to ensure that a minimum number of ECP's are included in provider networks. Specifically, we support the proposal that in each geographic region, 15% of every Qualified Health Plan's provider network must be comprised of providers who are employed by or contracted with Essential Community Providers.

Establishing this basic threshold will ensure adequate access to ECP's; provide a clear guidance for QHP's; and will create a simple format to monitor compliance and improve continuity of care as low-income individuals move from public to private coverage.

Participation of Medi-Cal Managed Care Plans in the Exchange

As a public hospita l system that works closely with our local Medi-Cal managed care plan, Central California Alliance for Health, we appreciate the Exchange's recogn ition of of the value of the participation of loca l Medi-Cal managed care plans as QHPs in the Exchange. To that end, we thank the Exchange staff for recommending proposals that encourage the participation of Medi-Cal managed care plans, including the allowance of sub-regional plans. However, in order for local health plans to meet all the plan requirements, they will have to undergo significant planning and development. While we are overall in agreement with the proposed NCQA Health Plan accreditation requirements the Exchange sets forth in Option B, we ask the Exchange to consider further extending the accreditation timeline to allow tor enough time for the local health plans to obtain the necessary accreditation requirements.

Standardization of Minimum Out-of-Network Benefits- maximum fee limitation

NMC has concerns about the proposed recommendation that could set limits on payments to providers for out-of-network services to Exchange enrollees. This proposed recommendation could cause harm to safety net hospitals that provide significant trauma, burn and emergency care to all Californians. The Exchange's proposal to standardize out-of network benefits which could limit payments to prov iders could negatively impact our public hospital systems by reducing revenues that are needed to ensure we can continue to prov ide comprehensive services. Moreover, maximum out-of-network rates to providers could create disi ncentives for QHPs to contract with public hospital systems and other safety net providers who would likely qualify as ECP's. For these reasons, we echo CAPH's recommendation to exc lude this proposal from the final set of Exchange regulations.

Thank you very much for your thoughtfu l work in creating a Health Benefits Exchange that will help promote the health and health care for all Californians. We and other public hospital systems stand read y to partner with you to improve health care delivery and supp01t a system that will ensure access to high quality care for all Californians.

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