ALAMEDA COUNTY MEDICAL CENTER

Highland Hospital Campus Fairmont Hospital Campus
John George Psychiatric Pavilion
Ambulatory Health Care Services

August 6, 2012

California Health Benefits Exchange
2535 Capitol Oaks Drive Suite 120
Sacramento, CA 95833

Submit via email: info@hbex.ca.gov

Dear HBEX Board and Staff,

On behalf of the Alameda County Medical Center and our patients, I am writing to provide feedback on your proposed recommendations for Qualified Health Plans (QHPs) in the Exchange. We appreciate 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.

Alameda County Medical Center (ACMC) is the designated public hospital system in Alameda County and is licensed for 475 beds and serves approximately 95,000 patients. ACMC is comprised of three hospital campuses and three freestanding Federally Qualified Health Centers throughout Alameda County located from Oakland to Newark. ACMC is a well-known regional trauma center and operates one of the nation's busiest emergency departments with over 90,000 visits annually. We provide 300,000 outpatient visits, 11,000 psych ED visits, 13,649 inpatient admissions, 29,333 in and outpatient surgeries, and 2,246 patients are served by our trauma center. We provide a full continuum of care including health promotion and prevention, primary care, chronic disease management, specialty outpatient services in over 35 medical and surgical specialties, labor and delivery, acute medical and surgical inpatient care, acute rehabilitation, skilled nursing, and acute psychiatric in patient and emergency services. We are also a well respected and competitive teaching hospital.

ACMC has a track record of providing services and working in partnership with our diverse populations. For example, 35% of our patients are Latino, 28% are African American, 11% are Asian/Pacific Islanders, 13% are White with the rest identifying as other (which likely includes individuals from South East Asia, the Middle East and biracial individuals). Our patients tend to be low income and working poor. Thirty percent of our patients are uninsured, 48% are covered under Medicaid, 15% are covered through Medicare and 7% are commercial payors. As such, we recognize the need to provide culturally competent care, which is reflected in our diverse workforce. Furthermore, ACMC provides translation services in over 35 languages; a service that is a testament to ACMC's ability to address the needs of limited English speaking populations.

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The following are our recommendations regarding some of your specific proposals.

Essential Community Provider

Essential Community Provider Definition Recommendation: Adopt a definition that differentiates providers that substantially serve a patient population that is disproportionately low-income, medically underserved and uninsured.

As a traditional safety net provider that started serving patients in the late 1800s, we have served low-income, Medi-Cal and uninsured patients for decades. ACMC started serving Medi-Cal patients once the program was created and has always served low-income patient, the uninsured and those unable to pay for over 100 years. In the tradition of county public hospitals and as a public authority, we continue to serve patients regardless of their ability to pay. Given our mission, 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 important 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 disproportionate numbers of Medi-Cal and uninsured, and a broad approach which, in taking all comers, fails to 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 forth in section (ii) above shall include those hospitals designated by the Department of Health Care Services as a disproportionate 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)(1) 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(l)(2)(B) 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 2110(c)(9).

(d) **"Substantial[1]"** as set forth 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 10% 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 supports 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. Furthermore, the definition must also require providers to articulate the role they play in providing care to not only California's Medi-Cal but also the state's uninsured population.*

Meeting Sufficient ECP Access Standards Recommendation: Require a threshold for all Qualified Health Plans to ensure that a minimum number of Essential Community Providers are included in provider networks; 15% of a QHP must be comprised of providers who are employed by or contracted with ECPs.

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 certain 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.

Payment Rates to Federally Qualified Health Centers Recommendation: Require QHPs to contract with FQHCs and be paid at the PPS rate.
Federally Qualified Health Centers have an excellent track record of cultural and linguistic competence and expertise and a deep knowledge of the complexities of low-income patients. We believe in affordable products that make sense and also meet the needs of culturally diverse low-income patients. Requiring payment at fair compensation can negatively impact the primary care system by reducing revenues that are needed to ensure that FQHC's can continue to provide comprehensive primary care services that also meet the needs of our very diverse (racial and ethnic, as well as linguistic) Bay area population.

Participation of Medi-Cal Managed Care Plans in the Exchange
Recommendation: Extend the accreditation timeline to allow for enough time for local health plans to obtain the necessary accreditation requirements.
As a public hospital system that works closely with our local Medi-Cal managed care plan, particularly the Alameda Alliance for Health, we appreciate the Exchange's recognition of the value of the participation of local 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 for enough time for the local health plans to obtain the necessary accreditation requirements.

Standardization of Minimum Out-of-Network Benefits- maximum fee limitation
Recommendation: Exclude this proposal from final regulations.
Alameda County Medical Center 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, such as us, that provide significant trauma and emergency care Bay Area residents.

ACMC is a well-known regional trauma center and operates one of the nation's busiest emergency departments with over 90,000 visits annually. ACMC's trauma center serves 2,246 patients and a significant number of our trauma patients are out of network as currently defined. Furthermore, we also see emergency and trauma patients that reside outside of Alameda County. We are only one of two trauma centers in Alameda County and have a critical role in both emergency (medical and psych) and trauma care.

The Exchange's proposal to standardize out-of network benefits would limit payments to ACMC (as a potential Essential Community Provider) and negatively impact our hospital system by reducing revenues that are needed to ensure that we can continue to provide comprehensive services that include emergency and trauma care. While we appreciate the concern regarding

the protection of consumers from higher costs, a maximum fee limitation on health plans for emergency room care, trauma, emergency psychiatry, and other critical services that may be needed by our local Bay Area residents could potentially reduce access to critical health care services for Alameda County and neighboring residents.

Moreover, maximum out-of-network rates to providers could create disincentives 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 exclude this proposal from the final set of Exchange regulations.

Thank you very much for your thoughtful work in creating a Health Benefits Exchange that will help promote the health and health care for all Californians. ACMC and other public hospital systems stand ready to partner with you to improve health care delivery and support a system that will ensure access to high quality care for all Californians.

Sincerely,

B. Patricia Barrera, JD
Director of Legislative Affairs & Community Advocacy

CC: Warren Lyons, CSIO, ACMC
Wright Lassiter, CEO, ACMC
California Association of Public Hospitals