AMERICA'S ESSENTIAL HOSPITALS

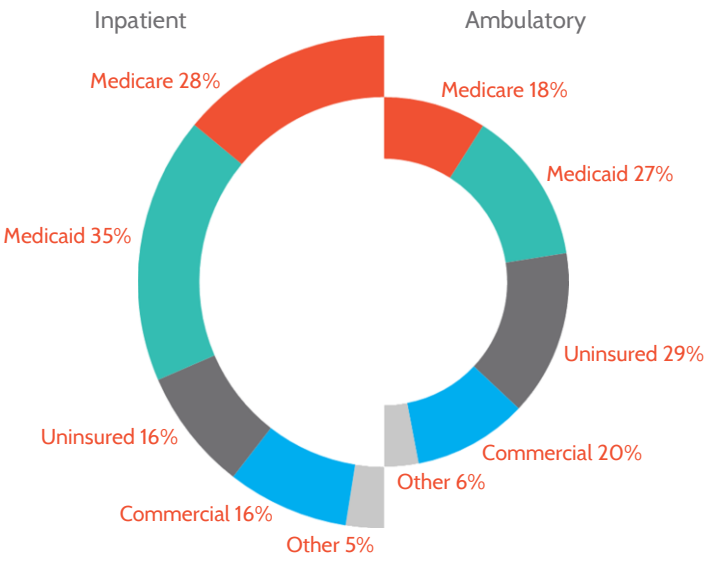
April 2014

Key Issues Affecting Essential Hospitals and Their Patients

Financial Challenges

Essential hospitals occupy a unique place in the nation's health care delivery system. Their key defining characteristic is a demonstrated commitment to treating all patients, including the most vulnerable. In 2012, 16 percent of our members' patients lacked insurance and 35 percent depended on Medicaid, on average. These patients are not only more likely to be poor and uninsured than those at other hospitals, but also are more likely to have multiple chronic conditions and face various barriers to access.

Inpatient and Ambulatory Utilization by Payer Mix



* Uninsured includes self-pay, charity care, and state/local indigent care.
** Other includes Veteran' Care, workman's compensation, and prison care

Due to their commitment to these uninsured, low-income, and other impoverished patients, essential hospitals have an average operating margin of -0.4 percent. This compares with 6.5 percent for all hospitals nationally. Because they have long operated with scarce resources, essential hospitals have learned to do more with less and have grown more efficient in providing care.

Essential hospitals could not keep their doors open without significant additional financial support from federal, state, and local governments. Payments to help offset the costs of caring for the uninsured, providing primary through trauma care and other vital community services, and absorbing Medicaid payment shortfalls are critical to these hospitals' health—and some of those funding sources are at risk:

- Essential hospitals rely on Medicaid and Medicare disproportionate share hospital (DSH) payments—vital funding streams targeted for deep cuts over the next decade (the Medicare DSH reductions already have started). Congress wisely chose to repeal or delay the first few years of Medicaid DSH cuts. But we remain deeply concerned about years of damaging cuts still to come.
- Many essential hospitals receive direct payments from local sources to help offset the cost of providing essential community services. But the nation's economic downturn has made this local support tenuous and a target of cuts that directly impact hospitals.

With the quickly changing landscape for coverage expansion and health care delivery, federal support for essential hospitals remains as critical as ever. Policymakers must stand up for patients and the hospitals upon which they rely by rejecting cuts that would threaten access to comprehensive, high-quality care.

Network Adequacy

The Affordable Care Act (ACA) requires all qualified health plans (QHPs) in health insurance marketplaces to include essential community providers (ECPs), which the law defines as those that predominately care for low-income and medically underserved people. ECPs include certain hospitals, community health centers, HIV/AIDs clinics, and family planning health centers. Nearly every member of America's Essential Hospitals is an ECP. But regulatory guidance on this requirement weakens the law's goals: Now, plans in federally facilitated and partnership states may include as little as 20 percent of available ECPs in their service area and as few as one provider in each ECP category. While the most recent guidance increased this requirement to 30 percent of ECPs, a QHP still may contract with as few as one ECP hospital in its geographic area.

When expansions in health insurance coverage are not matched with strong network adequacy protections, individuals and families are too often left without access to providers with the experience and expertise to meet their medical needs. These people—patients of essential hospitals—can face gaps in the continuity of care, disruptions to established relationships with providers, and obstacles to the timely delivery of critical services.

We need robust standards that ensure QHPs include an adequate number of essential hospitals in underserved areas within their networks. We also must discourage practices that limit access to essential hospitals, including exclusion of coverage for certain services and placement of these hospitals in high cost-sharing tiers.

Workforce

Current estimates predict a shortage of 90,000 physicians, split evenly between primary care and specialists, by decade's end. Left uncorrected, this severe physician shortage will disproportionately harm vulnerable patients, who already face limited access to providers and other barriers to care.

Members of America's Essential Hospitals include many of the nation's largest teaching hospitals and academic medical centers—indeed, more than two-thirds of our members are teaching hospitals. Overall, they make up just 2 percent of all hospitals nationally, but train 18,000 physicians each year, or 18 percent of physicians trained nationwide. Members of America's Essential Hospitals also train thousands of nurses and allied health professionals.

220+

Members of America's Essential Hospitals

18,000

Physicians trained annually by members

Much of the residency training these essential hospitals provide occurs with no federal support. We must ensure that adequate resources are available for training our future physicians and the other health care professionals who will help ensure vulnerable patients can access high-quality, affordable health care services.