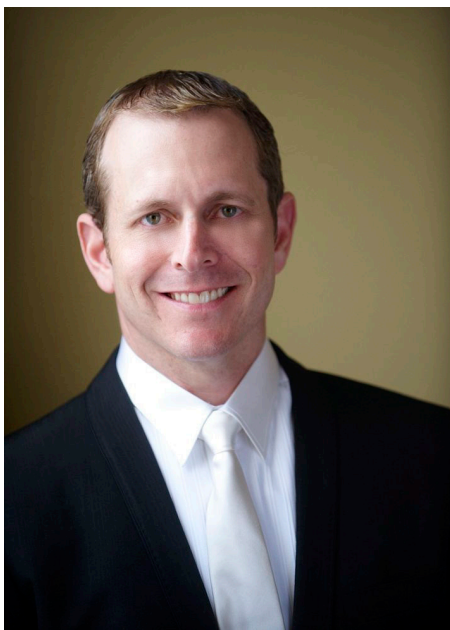


Health Care Reform: Walking the Fine Line Between Epic and Tragic

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The recent changes to the core structure of modern American health care are nothing short of epic, rivaled in historic scale only by the introduction of Medicare in 1965. Although each decade over the past 50 years has in some way used government programs and incentives in an attempt to urge health care to undergo recalibration as a means to establish industry stability, by the end of the first

decade of the 21st Century it had become evident that health care in the United States was fast becoming unsustainable as it existed. Enter health care reform.

Three years after the Federal Government passed the Affordable Care Act in an attempt to right the sinking ship, we the people are still waiting for the tide to turn. Having survived last summer's monumental challenge before the United States Supreme Court and a presidential election in November, the Affordable Care Act has not only emerged as the law of the land, it has cemented its place as health care's blueprint throughout America for decades to come. For California, however, the timing is unjust, as the perfect storm brought about by fiscal cliff/debt ceiling concerns heads straight for Sacramento from the east just as health care's versions of Scylla and Charybdis approach forebodingly from both north and south.

With Medicaid expansion just around the corner and the number of approved accountable care

organizations (ACOs) in the Medicare Shared Savings Program expected to double, California is not necessarily reveling in the joys of health care reform. Instead, public attention often focuses on the estimated 12 million undocumented aliens in the United States, three million of whom fall under California's aegis. Both inspiration and funding seem to be lacking for the nearly 200 hospitals residing in the 44 rural of California's 58 total counties who may have passed on the opportunity to form an ACO.

If a dearth of financial resources and 156,000 square miles of rural acreage were not enough to discourage the true pioneers of modern health care reform, California's strict prohibition on the corporate practice of medicine adds insult to injury, especially when federal regulations attempt to promote a collaborative new way to approach the delivery of health care that is usually forbidden under California law. Finding the minimum number of 5,000 Medicare beneficiaries needed to establish an ACO in Los Angeles County, with its 125 hospitals, or Orange and

Riverside Counties with their 60 hospitals, is no easy task. However, for those insistent on the idea of an ACO, the Medicare Bundled Payment Pilot Program (ACO Lite) is scheduled to begin in 2013, focusing on specific episodes of care rather than complete accountability for the delivery of health care to a predetermined group of Medicare beneficiaries.

Current nationwide economic challenges notwithstanding, starting in 2013 the Affordable Care Act requires certain taxpayers to contribute a collective \$318 billion over ten years to help finance Medicare, as well as an excise tax on the sale of certain medical devices. On top of this, California has recently increased both sales tax and income tax rates for some through Proposition 30, thereby ensuring its status as one of the highest taxing states in the nation. Furthermore, individual contributions to a flexible spending account for medical expenses can no longer exceed \$2,500 a year, while residents must also contend with a new 10% threshold for the itemized deduction for unreimbursed medical expenses (previously 7.5% of adjusted gross income).

Facing uncertain futures are California's Medi-Cal disproportionate share hospital payments and the California Medical Assistance Commission (CMAC), including the process by which hospitals in California negotiate and contract inpatient Medi-Cal rates. Already deprived of one percent of all Medicare reimbursements in fiscal year

2013 under the Hospital Value Based Purchasing Program, Medicare disproportionate share hospital payments are scheduled to change next October, the effect of which remains up for debate.

Although 2012 ended with a record breaking \$3.3 billion in settlements and judgments in civil cases alleging violations of the Federal False Claims Act, 2013 may still prove to be the year of compliance. The Affordable Care Act required providers to establish compliance and ethics programs that contain certain "core elements," which for now have been defined as those set forth in the Federal Sentencing Guidelines, as a condition to participate in Medicare, Medicaid, or any other federally funded program. Nursing homes in particular must meet heightened criteria come spring, with the possibility of enhanced requirements for other providers still looming in the periphery.

Overshadowed by the nation's focus on the current economic crisis, California hospitals must still comply with seismic safety deadlines over the next few years. On a similar time frame, Medicare and Medicaid eligible professionals must meet all meaningful use requirements under the Electronic Health Record Incentive Programs, while hospitals sort through the labyrinth of Stage Two requirements under the Health Information Technology for Economic and Clinical Health (HITECH) Act. When it comes to contemporary American health care, change is everywhere, and takes a variety of forms.

The speed at which health care reform appears to move can at times be dizzying, and its demands are often draconian at first glance. However, history has shown that health care in the United States is resilient and often finds ways to surprise even its toughest critics. Make no mistake, the Affordable Care Act is in many ways a trillion dollars gamble with a tri-fold agenda that attempts to improve the long-term health of Americans by promoting innovation in the delivery of medicine, placing stronger emphasis on the prevention of disease, and enhancing education in the adoption and maintenance of healthier lifestyles. Without such a nationwide commitment to change, our health care structure has little in the way of foundation on which to rest. Given the alternative, the epic solution may in this case be the only viable option.

Garner is an attorney and health care consultant, specializing in issues surrounding modern American health care in its climate of reform. His law practice focuses on health care mergers/acquisitions and regulatory compliance.

A former hospital CEO between 2002 and 2011, Garner is a Fellow designate of the American College of Healthcare Executives, and an adjunct professor of law at Pepperdine University where he teaches courses on Hospital Law and the Affordable Care Act.

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