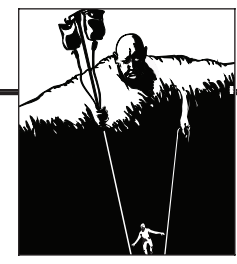

COST OF AGING

FEARS AND OPTIMISM

Without a margin, doctors cannot fulfill their medical mission.

BY JAMES T. CAILLOUETTE
FOR THE REGISTER

As a practicing orthopedic surgeon, member of the board of managers of a hospital, former president of the California Orthopedic Association and most importantly, a long-time member of the Orange County medical community, I have been engaged in discussions concerning health care reform for years.

The question of how the Affordable Care Act will impact the health care that we provide is burning in my mind. I care about equity and efficiency concerning health care. They are the two sides of the reform coin. In this context, I admit I am not a policy expert. But I do have some early fears and some early optimism about some of the proposed changes in Medicare and its relationship to the ACA.

I am in my twenty-fifth year on staff at Hoag Hospital, and since 2010, the Hoag Orthopedic Institute. Since joining the founding board of managers of the orthopedic hospital, I have learned the facts of how a hospital runs – how much care costs and what is paid for by the various payers, such as Medicare, Medicaid, Blue Cross, Cigna, etc.

To sustain our ability to fulfill our mission to care for those who cannot afford to pay for their care entirely, particularly low- and moderate-income households, we must be able to secure a positive cash flow and extra dollars at the margin. We need top notch nurses, pharmacists and support staff. We need state-of-the-art equipment, and we are required by CMS to have a highly integrated electronic medical-records system. In addition, the state and federal regulatory burden is extremely costly in health care compared to other industries.

There is a clear need to "bend the cost curve" to create sustainable funding and to reduce the rate of public spending growth. Yet, the solutions proposed by the Obama administration and Congressional leaders for

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further cuts in reimbursement levels could seriously impact the mission of doctors and hospitals.

As a personal example, between 1992 and 2008, the Medicare reimbursement that I received to perform a total hip or knee replacement was reduced 64% in inflation-adjusted dollars. It has been reduced further since 2008. While there has been an increase in overall health care spending, as this example shows, those providing the care are not the reason.

In California, over 90 percent of hospitals sustain a net loss on the care provided for Medicare patients, and an even greater loss for Medicaid patient care. In this context, expectations are that 30,000,000 new individuals will be covered soon by Medicaid and the ACA. I applaud this. However, without sustainable and predictable funding to those providing care and the facilities they work in, we will not be able to fulfill our mission. The 25 percent to 30 percent cost shifting that occurs between commercial insurance (Blue Cross, Cigna, etc.) and Medicare/Medicaid will eventually go away as a result of implementation of the ACA. Put another way, the funds that currently prop up the cost of care for the uninsured and underinsured will erode, and doctors as well as hospitals may be forced to opt out in order to remain financially viable.

I fear those not directly involved in providing care will dismiss these statements as self-serving. They are not. I am concerned that we need to move beyond rhetoric to define a health care system that is efficient, chooses treatments after weighing benefits over costs and provides quality care to all patients, including low-income patients.

The best way to look at reforms is to focus on rewarding the best patient outcome and experience at the lowest cost. Government subsidies should be gradually targeted toward low-income folks. Hospitals and doctors who provide a value-based care experience should be rewarded with sustainable, rather than continually shrinking, reimbursement. Both President Obama and Congressman Ryan have indicated a willingness to support the payment for health care through a bundled payment (a single payment shared by all who provide care). The payment will make it easier for all those providing care to work together as efficiently and effectively as possible.

90%

In California, over 90 percent of hospitals sustain a net loss on the care provided for Medicare patients, and an even greater loss for Medicaid patient care.

We at Hoag Orthopedic Institute have been a part of a statewide pilot program for several years to demonstrate this concept. It works. Let physicians and hospitals work together to create ideal solutions for their circumstances. Ideally, through reengineering their health care processes, hospitals and their physicians will make a fair margin. They then will be able to delegate a portion of that margin toward those who cannot afford care. If the reformed Medicare, Medicaid and the ACA reduce reimbursements without creating opportunities for positive creative change, there will be a dramatic reduction in the ability to provide care for the Orange County community.

No margin, no mission. Simple.

CONTACT THE WRITER:
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PATIENT-CENTERED CARE

At the controls of health care should be the patients themselves.

BY CHARLES P. VEGA
FOR THE REGISTER

A 36-year-old man with a rare kidney disorder returns to clinic time and again. With each visit, he is experiencing more signs of physical decline and disability. He should receive hemodialysis immediately, but he has not met the criteria to qualify for Medi-Cal.

A 64-year-old woman experiences increasing amounts of vaginal bleeding along with abdominal pain. Her symptoms are clearly indicating uterine cancer. She cannot afford to see a specialist but wants to hold on until she qualifies for Medicare in six months. Until then, she continues to experience symptoms and the anxiety of knowing that a tumor grows inside her.

Another patient in her early 60s is experiencing macular degeneration, which is gradually robbing her of her vision. She has seen an ophthalmologist, but nothing can be done because she lacks health insurance and cannot afford surgery. She is going blind and hopes that she can be approved for Medi-Cal prior to losing her sight entirely.

These are the types of cases we see every single day at the UC Irvine Family Health Center in Santa Ana, the county's largest provider of safety net care. Our practice provides preventive care, treats common and esoteric chronic diseases and offers multiple services to provide a path to wellness for our low-income patient population. We treat patients regardless of their insurance or documentation status. It brings us face to face with the impact of poor access to health care services among citizens and non-citizens alike, and our patients are truly inspirational in their courage and perseverance, in spite of severe physical and emotional challenges.

The majority of our patients have Medicaid and/or Medicare. These programs allow us to care for our community and prevent serious illnesses. Thanks to the Patient Protection and Affordable Care Act, which puts a premium on preventive health care, we can do more than ever to practice the most cost-efficient

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and patient-centered medicine in promoting wellness.

But even with reform, the health system is now and will remain broken. We must search and scrounge for alternatives for low-income patients.

Physicians need to be involved in the discussion of health care policies and regulations. We understand the human toll of reducing access to Medicare and Medicaid. Limitations on enrollment and needed bottom-line care in these programs as well as the Affordable Care Act will cost lives or reduce the quality of life for many.

The public generally views physicians in high esteem. This is a privilege and opportunity, and we cannot waste the chance. As a profession, we have to look beyond our self-interest in advocating for a smart and sustainable system that expands both access and quality of health care. Low- and moderate-income Americans are key stakeholders in the health care debate, yet they are also the group that is most lacking in terms of organization and resources. As is often the case, those with the greatest need have the least power in influencing critical decisions.

As physicians, we need to employ our organization, our expertise and our passion in advocacy for those who lack a voice. Just like initiating dialysis to save the life of someone in renal failure or holding the hand of a woman hearing the worst news of her life, we need to be there for our patients. We must embrace new models of care that change the role of the physician.

Our patients should truly be at the controls, and physicians should be part of a team of allied health professionals providing needed services. Patient-centered care will require new approaches to reimbursement that reward healthy outcomes. This is the most effective tool to control costs, provide more quality, efficiency and equity in health care. Together with our patients, we will achieve great things. They cannot wait.

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