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An Endangered Institution



Craig B. Garner

Across the nation, America's community hospitals are under siege. Once considered indispensable to our health care system, the twenty-first century finds the local hospital fighting an uphill battle against a convergence of factors that favors the sharing of resources by multiple facilities. Rising health care expenses, challenging regulatory hurdles, and a reimbursement structure in the midst of transition all bear some responsibility for the obstacles faced by today's community hospital. Nowhere is this phenomenon more pronounced than in California, where regular hospital closings amid an ever-growing population stand as incentive for remaining hospitals to team up (or remain teamed up) under the potentially false notion that in modern American health care, there is safety in numbers.

LEARNING FROM PAST MISTAKES—WHAT HISTORY REVEALS ABOUT HEALTH CARE

Understanding the historical evolution of the American hospital is fundamental to recognizing the core problems faced by smaller hospitals today. From the 1736 opening of an almshouse in New York City (which would eventually become Bellevue Hospital) through the expansion to nearly 5,000 hospitals by the 1920s, and continuing through the post-1960 shift toward multifunctional facilities, health care has responded to the socioeconomic and political influences of each era. A trend of multihospital systems replacing freestanding community hospitals picked up speed after 1965, driven largely by a combination of economic factors (including the creation of Medicare) and technological advances in medicine. The five hospital consolidations noted in 1961 ballooned to upwards of fifty per year in the 1970s. By the 1980s, an estimated thirty percent of the hospital beds in the United States existed within hospital systems.¹

In 2008, the American Hospital Association estimated that almost half of the nearly 6,000 U.S. hospitals belonged to a grouping of hospitals, defined as either "multihospital" or "diversified."² Even many operators of non-profit, faith-based facilities, descendants of the original almshouses and charity hospitals, have sought refuge in consolidation, including the Sisters of Charity, the Benedictine Sisters, the Daughters of Charity, the Sisters of Mercy, and the Ursulines, among others, who for the most part have followed market influences to become part of larger regional "systems."³

For its part, California has played a leading role in the institutional transformation that has come to define the status quo of American hospital care today. By focusing on specific instances in which local hospitals have been forced to close, we can better identify the forces at work behind the scenes at these facilities, thereby highlighting recent shifts in California's health care market and identifying potential flaws in hospital regulatory oversight. This serves as the backdrop to many of the consolidations and mergers, past, present, and future, and prepares us for a better understanding of the future of America's hospitals. Here are some examples of the many closings in California:

CALEXICO HOSPITAL— CALEXICO, CALIFORNIA

Calexico Hospital was one of California's smallest hospitals in one of the state's most economically depressed communities. After 47 years of service, the 34-bed facility closed in October 1998, leaving the Imperial Valley border town of 24,000 without a hospital. The governing body of the hospital was forced to surrender its license to the Department of Health Services (California's predecessor to the California Department of Public Health), which cited repeated violations of state health codes

involving record keeping, cleanliness, and training of personnel. Before the hospital closed, Medicare and Medi-Cal decertified it. Eight years after the hospital closed, a local jury found for the plaintiffs in a suit blaming the hospital's closure on the actions of "rogue" state regulators and awarded Calxico's owners \$12 million.⁴

DESERT PALMS COMMUNITY HOSPITAL—PALMDALE, CALIFORNIA

When Desert Palms closed in 1996, the 110,000 townspeople of Palmdale were left without a hospital or emergency department. With over 90 percent of Desert Palms' admissions coming from the emergency department, hospital administration blamed the financial impact caused by a disproportionately high number of uninsured patients and an infrastructure destabilized by the entry of health maintenance organizations.⁵

KINGSBURG DISTRICT HOSPITAL—KINGSBURG, CALIFORNIA

Prior to its closing in May 2010, Kingsburg District Hospital was one of the last remaining rural hospitals in the San Joaquin Valley. Since its opening in 1961, Kingsburg had managed to overcome bankruptcies and cutbacks to continue providing service to local residents.⁶

LINDA VISTA COMMUNITY HOSPITAL—LOS ANGELES, CALIFORNIA

Originally named Santa Fe Coastlines Hospital, this facility was constructed in 1904 to provide medical care to Santa Fe Railroad employees. In its early days the hospital thrived and in 1924 the hospital expanded to accommodate an increased patient census. After the Second World War, East Los Angeles County slowly transformed into a less affluent area, and in turn the hospital faced less funding. When Linda Vista tried to reduce its operational expenses in response, it was blamed for

an increase in facility death rates. By the 1980s, Linda Vista Community Hospital was regularly treating a fair number of gunshot wounds and stabbings from the local neighborhoods, which did not help its mortality statistics. Further changes in hospital demographics and an increase in uninsured patients ultimately forced it to stop accepting ambulance runs in its emergency department. The quality of care at Linda Vista Community Hospital continued to decline as doctors moved to other hospitals throughout Los Angeles County. Finally, in 1991, the hospital ceased operations.⁷

MARINA HILLS HOSPITAL—LADERA HEIGHTS, CALIFORNIA

After operating under bankruptcy protection for some time (and also asking employees to temporarily work without pay), Marina Hills was forced to close its doors in 1990, citing the continued failure of California's Medi-Cal system to reimburse nearly \$1 million owed for patient care.⁸

MARTIN LUTHER KING, JR./KING DREW MEDICAL CENTER—WATTS, CALIFORNIA

Proposed after the Watts riots to serve the low income area in South Central Los Angeles, this facility came under fire from the Centers for Medicare & Medicaid Services in 2004, citing non-compliance with Medicare and Medicaid requirements, including a finding of "immediate jeopardy" due to substandard care. This exacerbated a rift between Los Angeles County administrators and local community leaders. The hospital ultimately closed in 2007 and converted to an ambulatory care center.⁹

ROBERT F. KENNEDY MEDICAL CENTER—HAWTHORNE, CALIFORNIA

Treating patients in California's South Bay for over 70 years, RFK Medical Center was a comprehensive medical complex with a multi-specialty medical staff and 24-hour emergency department that provided adult and pediatric care. When the 274-bed facility shut its doors in 2004, it was the sixth Los Angeles County emergency department that year to close due to financial concerns, a trend many attributed to the financial losses incurred by treating uninsured and underinsured patients.¹⁰

SAN DIEGO GENERAL HOSPITAL—SAN DIEGO, CALIFORNIA

Built in 1972 with assistance from the city, the hospital quickly experienced financial difficulties due to its largely uninsured and underinsured patient population. Struggling for nearly 20 years as Southeast San Diego's only hospital, ultimately high debt and lack of government funding forced a shutdown in 1991, prompting City Councilman Wes Pratt to state: "It's a shame we can spend billions liberating Kuwait but we can't find the funds to free our citizens from disease and inadequate health care right here in America."¹¹

SANTA TERESITA HOSPITAL—DUARTE, CALIFORNIA

In 1930, the Carmelite Sisters of the Most Sacred Heart founded Santa Teresita Hospital as a sanitarium. By the mid-1950s, it upgraded to an acute care facility. In 1964, the hospital added a skilled nursing facility and continued to expand, including the construction of an office center in 1981 and surgery wing in 1986. The hospital closed its 30-bed acute care facility in January 2004, citing California's implementation of statewide nurse staffing ratios as a contributing factor.¹²

ST. LUKE MEDICAL CENTER— PASADENA, CALIFORNIA

For almost 70 years, St. Luke Medical Center played a critical part in the delivery of health care for Pasadena, Altadena, and Los Angeles County. St. Luke provided emergency, inpatient and surgical services, including obstetrics, in addition to a transitional/skilled nursing unit. In 2002, the 165-bed hospital was closed by former owner Tenet Healthcare Corporation, citing poor financial performance.¹³

TUOLUMNE GENERAL HOSPITAL— SONORA, CALIFORNIA

Forged by an informal partnership between local governments and merchants, this hospital formed one of the oldest health care “systems” in the nation. Tuolumne General was built in 1849, offering a range of medical, surgical, and diagnostic services. On July 1, 2007, Tuolumne General closed its emergency department as well as all ancillary services, citing financial difficulties from operating an emergency department. Just before closing, a study concluded that only 41 percent of the emergency department visits were actual emergencies.¹⁴

BETWEEN A ROCK AND A HARD PLACE

As the above stories illustrate, fundamental changes to the nation’s health care infrastructure over the past 65 years have forced hospitals to work within boundaries created by seemingly contradictory forces. On the one hand, hospitals exist within an industry that historically received public support even when burdened with mounting expenses and a shrinking pool of funds available for reimbursement. On the other hand, today’s hospitals face tough regulatory scrutiny from both federal and state agencies whose mission includes reducing the rate of increase in health care expenses in the U.S.

In some ways this modern day dilemma may have begun in 1946 with the Hospital Survey and Construction Act (the “Hill Burton Act”)¹⁵, whereby Congress sought to disburse nearly \$4 billion to hospitals throughout the United States. The Hill Burton Act sought to create 4.5 hospital beds per 1,000 people, while simultaneously advancing the availability and quality of health care nationwide.¹⁶ Its passage resulted in enabling hospitals to work together by sharing federal funds, allowing local facilities to pool their collective Hill Burton Act monies with other resources so that the needs of the entire community could be met.¹⁷ If one hospital was in need of equipment, a hospital down the street was happy to help, creating a symbiotic bond within the community.¹⁸

However, such inter-hospital cooperation would be impeded by a later Act of Congress. Created in 1965, the Medicare program¹⁹ divided local hospitals. Under Medicare’s cost-based reimbursement structure, separate institutions eventually became prohibited from sharing treatment expenses without impacting their own reimbursement. This removed any incentive for local cooperation and instead promoted self-standing entities dependent on government programs.

Another significant change to the structure of American hospital care came in 1983 with the introduction of Medicare’s diagnosis-related groups (“DRGs”), a system that largely replaced cost-based reimbursement with a predetermined rate based upon patient illness and diagnosis.²⁰ This system forced hospitals to be mindful of health care costs²¹ and marked a historical shift in the relationship between health care provider and hospital administrator. From this point on, administrative forces held perhaps as much sway over an inpatient’s treatment as the clinicians in charge of providing actual care.

In California, as in the rest of the nation over the last two decades, health care spending has grown steadily. Further, the state’s population has continued to increase even as the number of hospitals between Del Norte and Imperial Counties has decreased.²² There has been close to a 10 percent reduction in the number of hospital beds in California between 2002 and 2009.²³ Even so, hospitals have remained a major point of access to the health care system in large part because of their emergency departments. The 1986 Emergency Medical Treatment and Active Labor Act (“EMTALA”)²⁴ requires hospitals to provide a specified level of care to anyone presenting for emergency medical treatment regardless of citizenship, legal status, or ability to pay, or risk the imposition of hefty fines or even termination of participation in federal health care programs.

That medical facilities have resorted to mergers and consolidations in an effort to stay afloat in such a climate should come as no surprise. Yet a recent federal inquiry into this trend of hospital mergers appears to presume that hospital consolidations increase costs to Medicare, private health insurance, and individuals.²⁵ While studying the impact of hospital consolidations on health care expenses is a reasonable inquiry by the federal government, it appears too late to have any public policy impact on the wave of consolidation in our health care system. Nor will it reverse the statistics relating to the decreasing number of emergency departments available both state and nationwide, especially in urban neighborhoods.²⁶ If left unchecked, the strain of regulatory and financial pressures on today’s hospital facilities may ultimately force more closures.

THE TRUTH BEHIND SAFETY IN NUMBERS

Though some in the media have been quick to draft the obituary of California's health care system, one does not hear such fatalism from hospital executives—or perhaps it is postponed by the series of programs (discussed below) that have redirected billions of dollars as stopgap measures. However, this massive infusion of funds may sidestep the core issues at hand, and may expose smaller hospitals within the state to greater risk.

For example, the Medi-Cal disproportionate share program (“DSH”)²⁷ has to date provided more than \$2.2 billion in supplemental funding for those California hospitals treating a large number of Medi-Cal and low-income patients. One of the tools behind the state's DSH program is a mechanism to “reimburse” all hospitals that provide vital health care services to a certain demographic that offers a traditionally low reimbursement rate in return. By offering financial incentives for these hospitals to continue to treat low-income patients, the state hopes to ensure continuity of care for everyone. Yet, being so heavily dependent upon such financial “bonus” funds comes with its own challenges and risks. The dependence on such payments can mask the underlying financial weakness of the institution. Far too often, small community hospitals find themselves struggling to survive on a daily basis, hoping to stay open long enough for DSH funds to replenish their coffers and start the process anew the following year. Even so, a hospital can do well by the state's DSH program, provided it has the necessary infrastructure to ensure sustainability during the balance of the year. Larger hospitals and systems can participate in the DSH program as well, and are often more prepared and better suited to engage in this program financially.

Likewise, the state's Hospital Fee Program,²⁸ an innovation of sorts created by the Medi-Cal Hospital Provider Rate Stabilization Act, brought \$2.6 billion in funding to eligible hospitals across California. By authorizing a statutory fee on most hospitals in California, the Hospital Fee Program raised sufficient funds so California could qualify for federal matching monies. While this program was a huge success in redirecting revenue to California hospitals in a time of great need, the logistics of the program often proved challenging, even though the rewards far outweighed the obstacles. Participation for certain hospitals required an initial investment into the program. Even though this initial financial outlay by the hospitals was short in duration and well worth the investment, it posed problems to cash-strapped community facilities nonetheless. While by no means the intent of the program, few would argue that larger institutions with the ability to absorb such a brief but costly investment fared better through this challenging aspect of the program.

Further assistance is available to hospitals through the California Medical Assistance Commission (“CMAC”), a state entity charged with the task of negotiating Medi-Cal contracts with hospitals on behalf of the state.²⁹ It also oversees the Private Hospital Supplemental Fund,³⁰ disbursement of monies under the Distressed Hospital Fund,³¹ and the Construction and Renovation Reimbursement Program.³²

Another example benefiting the multihospital system can be found within the American Recovery and Reinvestment Act of 2009 (“ARRA”).³³ Under ARRA, certain standards governing electronic health care transactions covered by the 1996 Health Insurance Portability and Accountability Act (“HIPAA”)³⁴ were reinforced and recalibrated under what

is now known as the Health Information Technology for Economic and Clinical Health Act (“HITECH”).³⁵ Seeking to enhance patient privacy rules in the digital age, HITECH also provides a financial incentive to qualifying hospitals that make “meaningful use” of electronic health records (“EHR”) within specific parameters set forth by the federal government. Although the three stages of requirement are strict and as yet undefined in their totality, hospitals that can afford such improvements to their information technology infrastructure and are able to comply with these specific requirements may in the future come to enjoy federal incentives with base payments starting at \$2 million.³⁶ Those that fail to comply, however, will see frightening Medicare payment reductions looming in the distance.³⁷

SOME FEDERAL SOLUTIONS

Buried within the 2,700 pages of 2010's Patient Protection and Affordable Care Act (“PPACA” or “health care reform”)³⁸ exist a number of pilot programs³⁹ and preventative health care services, each with significant innovations, specifically designed to reverse the trend in health care spending.⁴⁰ Earlier this year, the federal government released the long awaited and much anticipated regulations defining Accountable Care Organizations (“ACOs”).⁴¹ Since proper formation of ACOs under the regulations may necessitate a sizeable, seven-figure capital commitment out of reach for many California hospitals, the future of ACOs in California remains uncertain, even with the statutory revisions released by the federal government in October 2011.⁴² Previously published details on the federal government's Pioneer Accountable Care Organization Model (the “Pioneer ACO Model”)⁴³ have spurred some interest across the state by creating a “fast-track” for implementation. Set to take effect in 2012,

the federal government's plan for ACOs hit some bumps in the road as several major institutions responded to the proposed regulations with outright rejection.⁴⁴ Although many industry-wide concerns were addressed in the October 2011 final regulations, it is too early to gauge their impact on actual implementation of ACOs. Needless to say, the fate of ACOs is a discussion worthy of its own study beyond the scope of this article.

The federal government is also trying to promote collaboration in the health care sector by encouraging providers of all types to participate in the Bundled Payments for Care Improvement Initiative.⁴⁵ Announced in August 2011 under the authority of PPACA, this initiative is designed to align reimbursements for health care services with select episodes of care (e.g., heart surgery, hip surgery, etc.) instead of the traditional billing process that typically results in any number of separate bills for different elements of a single hospital stay.⁴⁶ While the hope is that the bundled payment initiative will lead to greater collaboration between and among different providers and thereby save health care resources, such a program may be more challenging for smaller hospitals with limited resources and fewer clinical participants from which to select.

THE FUTURE OF MEDICARE REIMBURSEMENT

Nearly every community hospital in California relies upon Medicare reimbursements to survive, and Medicare has been known to set the standard that other payers follow. Last April, CMS published its plan for reimbursing hospitals based on performance in specific quality measures with a particular emphasis on patient satisfaction.⁴⁷ The effect this will have on hospital reimbursement could be epic. A system that has historically been

based on cost and volume could transition into one focusing primarily on quality and performance.

Accordingly, a hospital's chance of survival in Medicare's new world may ultimately depend on the sophistication and implementation of its core systems (both technical and practical) with little room for error. In this vein, Medicare's Hospital Value-Based Purchasing Program may create a disadvantage for freestanding community hospitals, lacking the resources of larger, better funded institutions, to both implement and monitor all of the components established by Medicare to be eligible for reimbursement based on quality and performance.⁴⁸

As hospitals big and small focus on Medicare's new way to pay, they also must be mindful of the ways in which Medicare now polices itself. Under the 2003 Medicare Prescription Drug, Improvement, and Modernization Act ("MMA"),⁴⁹ Congress directed the federal government to identify and recover improper Medicare payments through the use of Recovery Audit Contractors ("RACs"). The Deficit Reduction Act of 2005 ("DRA")⁵⁰ introduced the Medicaid Integrity Program ("MIP") and Medicaid Integrity Contractors ("MICs"). Like them or not, hospitals must be prepared to respond to the influence of these integrity programs, lest they find themselves compounding or exceeding the \$875 million recovered from hospitals under the program's initial RAC demonstration project.⁵¹

To be sure, the situation looks somewhat grim for the community hospital in our modern health care climate. In dire straits even before the passage of PPACA, today's local hospital faces mounting pressure from all sides on its mission to provide not only quality health care but a sense of security to the community it serves. Lacking the

necessary resources to effectively combat rising health care costs and the ever-expanding regulatory oversight, the smaller facility must be savvy in its approach to our nation's new reimbursement structure if it is to maintain its existence. In order to survive, this once foundational institution must find ways to adapt within a constantly evolving health care structure for which health care conglomerates appear better suited.

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ENDNOTES

1 See, e.g., Johnson, Donald E. L., *Multihospital System Survey*, 11 *Modern Healthcare* 80 (April 1981); Starkweather, David B., *Hospital Mergers in the Making* (Health Administration Press, 1981).

2 American Hospital Association, *Hospital Statistics* (1981) (a multihospital system connects two or more hospitals through a central organization via ownership, leasing, or otherwise).

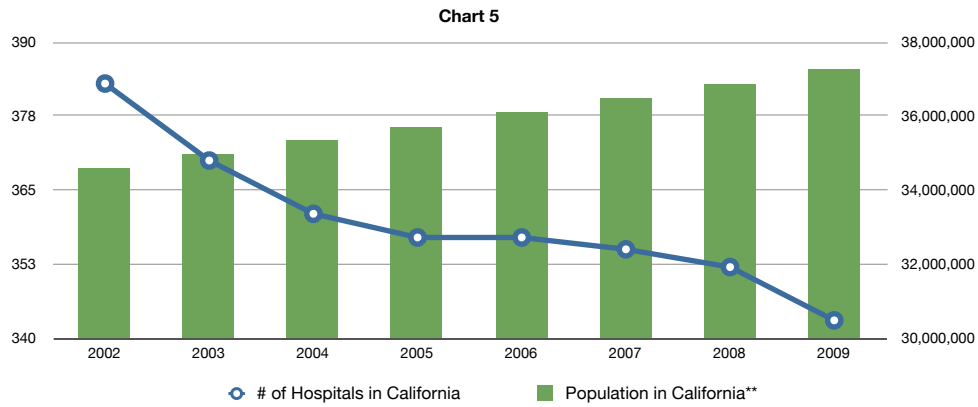
3 See, e.g., Risse, Guenter B., *Mending Bodies, Saving Souls*, 522–24 (Oxford University Press, 1999); Starr, Paul, *The Social Transformation of American Medicine*, 172–77 (Basic Books, 1982).

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5 See, e.g., Maeshiro, Karen, "Palmdale's only Hospital to Shut Down." *Daily News* (Mar. 9, 1996).

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- 8 See, e.g., Himmel, Nieson, "Funds Crisis Closes Doors of Hospital." *Los Angeles Times* (June 2, 1990); Garcia, Kenneth J., "Marina Hills Hospital Will Seek Bankruptcy Protection." *Los Angeles Times* (Jan. 31, 1990).
- 9 See, e.g., Chong, Jia-Rui, "Judge Denies Bid to Halt Trauma Unit's Closure." *The Los Angeles Times* (Dec. 3, 2004); Ornstein, Charles, "A Reeling King/Drew Receives Huge Blow." *The Los Angeles Times* (Sept. 16, 2004).
- 10 See, e.g., Chong, Jia-Rui, "Hawthorne Hospital to Shut Doors." *Los Angeles Times* (Sept. 24, 2004).
- 11 See, e.g., Monroe, Linda Roach, "General Hospital Succumbs to Money Woes." *Los Angeles Times* (Mar. 2, 1991).
- 12 See, e.g., Chavez, Stephanie, "Duarte Hospital to Close its ER." *Los Angeles Times* (Jan. 9, 2004).
- 13 See, e.g., Cischke, Steven, "Caltech sells St. Luke Property." *PasadenaNow.com* (Oct. 23, 2007); Vincent, Roger, "Developer Buys St. Luke Hospital." (Oct. 23, 2007).
- 14 See, e.g., Holton, Bob, "Remembering Old Tuolumne General." *Friends and Neighbors Magazine* (May 15, 2010).
- 15 Pub. L. 79-725.
- 16 See generally Lave, Judith R., *The Hospital Construction Act: 1948–1973* (American Enterprise Institute for Public Policy Research, 1974).
- 17 Lave and Lave, "The Hospital Construction Act;" Hochban, Jacquelyn, "The Hill Burton Program and Changes in Health Services Delivery." *Inquiry* 8 (Spring 1981).
- 18 *Id.*
- 19 Title 18 of the United States Code, as amended by Pub. L. 89-97.
- 20 Wilensky, Gail R., *The Economics of DRG-Based Physician Reimbursement* (Center for Health Affairs, 1985).
- 21 McClellan, Mark, *Medicare Reimbursement and Hospital Cost Growth* (National Bureau of Economic Research, January 1996).
- 22 See Table 1: Hospitals in California – 2002 to 2009. Between 2002 and 2009, health care spending increased by 34 percent, and there were 40 fewer hospitals available to treat about 2.7 million additional residents. (Source: U.S. Census Bureau's annual survey of state and local government finances.)
- 23 See, e.g., Hsia, Renee Y., M.D., "Factors Associates with Closures at Emergency Departments in the United States." 305 (19) *JAMA* 1978 (May 18, 2011) (noting that emergency department visits in the U.S. have increased by as much as 30 percent).
- 24 Pub. L. 99-272.
- 25 See generally *Health Care Industry Consolidation: Hearings before the Subcommittee on Health of the House Committee on Ways and Means*, 112th Cong. (Sept. 9, 2011).
- 26 See, e.g., Hsia, Renee Y., M.D., *supra*, 305 (19) *JAMA* 1978 (noting that between 1990 and 2009, one out of every four hospital emergency departments has shut down).
- 27 Cal. Welf. & Inst. Code §§ 14100–14124.11 (originating with the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35)).
- 28 See A.B. 1653 (Sept. 8, 2010) (codified by Cal. Welf. & Inst. Code §§ 141610.1–141610.17).
- 29 Cal. Welf. & Inst. Code §§ 14156–14165.11.
- 30 Cal. Welf. & Inst. Code § 14166.12.
- 31 Cal. Welf. & Inst. Code § 14166.23.
- 32 Cal. Welf. & Inst. Code § 14085.5.
- 33 Pub. L. 111-5.
- 34 Pub. L. 104-191.
- 35 76 Fed. Reg. 104, 31426 (codified at 45 C.F.R. part 164).
- 36 HITECH § 4301(c). When the final HITECH rules were published, multihospital systems sharing a single provider number were treated as a single hospital for purposes of incentive payments. Since then, Congress is reconsidering its approach and introduced the Equal Access and Parity for Multi-Campus Hospitals (HITECH) Act. See H.R. 2500, § 2 (112th Congress, July 12, 2011). If enacted, this bill would modify the incentive criteria to account for the higher implementation costs these hospital systems face as a result of having multiple hospitals and only one provider number.
- 37 42 C.F.R. § 495.4.
- 38 Pub. L. 111-148.
- 39 Sections 4104–4108 of PPACA, for example, require funding under Medicare and Medicaid to increase member participation in evidence-based healthy lifestyle programs such as cessation of tobacco use, lowering cholesterol and blood pressure, weight loss, and managing diabetes, among others.
- 40 Through a report issued by the PPACA's Prevention and Public Health Fund, the federal government estimates that a \$10 per person investment each year in community-based preventative health programs could result in an annual savings of more than \$15 billion over the next five years.
- 41 *Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Final Rule*, 76 Federal Register 19528 (Apr. 7, 2011) (to be codified at 42 C.F.R. part 425).
- 42 76 Federal Register 67973 (Nov. 2, 2011).
- 43 76 Federal Register 29249 (May 20, 2011).
- 44 See, e.g., Gold, Jenny, "'Poster Boys' Take a Pass on Pioneer ACO Program." *Kaiser Health News* (Sept. 14, 2011).
- 45 Separate from Section 3023 of PPACA (the National Pilot Program on Payment Bundling), this program is part of the Center for Medicare & Medicaid Innovation, established under Section 3021 of PPACA.
- 46 See *Affordable Care Act initiative to lower costs, help doctors and hospitals coordinate care*, HHS News (Aug. 23, 2011).
- 47 PPACA, § 3022; 42 C.F.R. § 425 (proposed rules as of April 7, 2011).
- 48 Although not part of any regulation, it is arguable that Medicare's new system emphasizing payment for performance effectively repeals its previous influence forcing hospitals to cease from sharing as they did under the Hill Burton Act.
- 49 Pub. L. 198-173.
- 50 Pub. L. 109-171.
- 51 See Centers for Medicare & Medicaid Services, *Status Report On Use of Recovery Audit Contractors (RACs) In the Medicare Program* (2007).

APPENDIX A



Hospitals in California -- 2002 to 2009

Year	No. of Hospitals in California	No. of Hospitals in U.S.	California's % of Total Hospitals in U.S.	Change from 2002	Population in California**	% Increase in Population from 2002	Health Care Spending in California***	% Increase in Spending from 2002
2002	383	4927	7.8%	0	34,595,700	0	\$41,100,000,000	0
2003	370	4895	7.6%	(13)	34,963,509	1.1%	\$44,400,000,000	7%
2004	361	4919	7.3%	(22)	35,335,229	2.1%	\$48,800,000,000	16%
2005	357	4936	7.2%	(32)	35,710,901	3.1%	\$52,000,000,000	21%
2006	357	4927	7.2%	(26)	36,090,567	4.1%	\$53,000,000,000	22%
2007	355	4897	7.2%	(28)	36,474,270	5.1%	\$57,900,000,000	29%
2008	352	5010	7.0%	(31)	36,862,052	6.1%	\$63,200,000,000	35%
2009	343	5008	6.8%	(40)	37,253,956	7.1%	\$62,200,000,000	34%

*Number of community hospitals only, which represent 85% of all hospitals according to American Hospital Association data for each year. Federal hospitals, long term care hospitals, psychiatric hospitals, and other similar institutions are not included.

**Numbers based on 2010 U.S. Census, 2000 U.S. Census, and estimates based on a comparison data from the years 2001 through 2009.

***U.S. Census Bureau's annual survey of state and local government finances.