From the Editor

The Real 800-Pound Gorilla

Richard G. Stefanacci, *DO, MGH, MBA, AGSF, CMD*

As the Founding Executive Director of the University of the Sciences in Philadelphia's Health Policy Institute, Dr. Stefanacci is building on his recent tenure as a Centers for Medicare and Medicaid Services (CMS) Health Policy Scholar. In that role, he spent a year working on policy development and implementation of the Medicare Part D Pharmacy Benefit, particularly regarding access issues for frail elders.

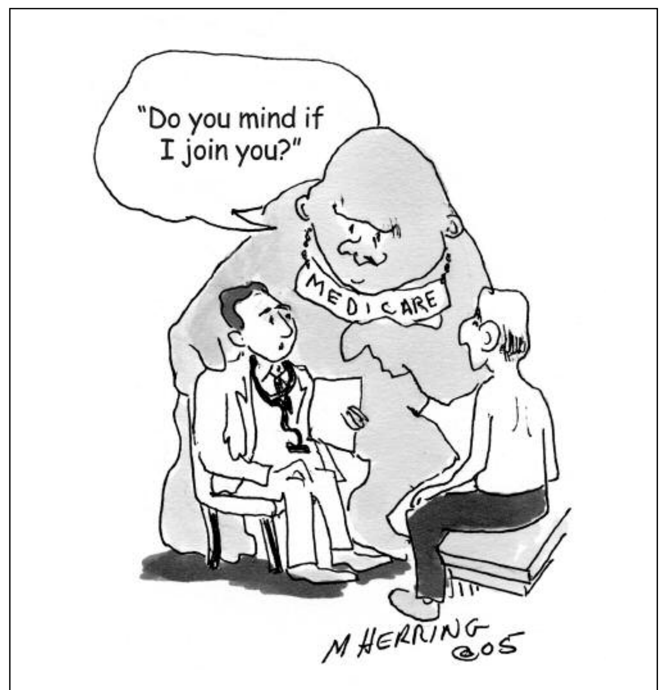
Dr. Stefanacci has a long and passionate history in long-term care (LTC). Having served as medical director for several nursing facilities and continuing care retirement communities, he is well versed in the needs of LTC facility residents. Additionally, Dr. Stefanacci's geriatric experience includes over a decade as a medical director of a large primary care private practice, a full risk provider group, a Medicare + Choice (M+C) HMO, and a Program for All-inclusive Care for the Elderly (PACE) initiative in Philadelphia.

A graduate of A.T. Still University, Dr. Stefanacci completed his clinical training at the University of Medicine and Dentistry of New Jersey in Internal Medicine and a fellowship in Geriatrics at the same institution.

Dr. Stefanacci serves on the board of trustees at A.T. Still and previously for the National PACE Association. He also is an active member of the American Medical Directors Association (AMDA), American Society of Consultant Pharmacists (ASCP), and American Geriatrics Society (AGS). Recently, he was recognized as a American Geriatrics Society Fellow (AGSF). In addition to writing and lecturing extensively, Dr. Stefanacci serves on the editorial boards of *Caring for the Ages, LTC Interface, Jefferson's Health Policy Newsletter,* and *The Journal of Quality Healthcare.*

"King Kong" not only describes this season's blockbuster movie, but it is also a metaphor for Medicare. Both are extremely large and powerful. Likewise, both have grown in prominence since their introduction many years ago and both are likely to continue to grow in importance.

Any health care provider caring for senior patients feels the effects of Medicare on a daily basis. Medicare provides coverage for a full range of health care services, which now also include prescription drugs for some 43 million Americans, making it the largest health care force in the industry. However, the reach and scope of Medicare will continue to grow only as long as the baby-boomer generation continues to age, technological innovations advance, and benefits expand, all at the same time that resources become less available, both in the form of federal and state funding, as well as in the number of physicians with expertise in geriatric care. Only through the introduction of efficient and effective systems of care in



daily practice will we be able to achieve optimum outcomes for all involved.

Although this may seem an overwhelming task, it is exactly where this publication *Medicare Patient Management* (*MPM*) intends to focus its attention. We intend to accomplish this by concentrating on the largest share of health care utilization and costs, which in the United States is among older adults with multiple chronic diseases.[1] By focusing on this population, identifying "best" practices from current real-world evidence, and translating this into practical terms so it can be implemented in your practice, we believe that we can improve outcomes for everyone. A concrete example of this is *MPM*'s "Take-Away Messages" that are included in all our feature articles. These not only help identify the critical points of each article, but also the return on investment for implementing these points in your practice.

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Again, *MPM* has a single goal, namely, to improve outcomes for Medicare patients and providers by providing critical information that can be used to positively impact each day. Of course, this massive an effort is only possible through a very involved interdisciplinary care team, and we are fortunate to have such a team. As you will notice from our Editorial Advisory Board, we have a complete team of experts from clinicians to policy experts to guide *MPM* on its mission. These experts will be utilized in *MPM*'s departments, which include a focus on medication management, legal and reimbursement issues, when and why to refer to consultants, the latest information system resources, and a forecast from key health care stakeholders to better prepare all of us for the coming changes.

And there is no shortage of changes occurring already. Starting with the recent introduction of new Medicare prescription drug coverage that will increase access to medications through lowered out-of-pocket expenditures, the administrative burden around the prescribing of medications for this population also may increase. In addition to Medicare Part D, major changes are occurring in the reimbursement arena. The 4.4% decrease in Medicare provider reimbursement was once again delayed and there will be no change in reimbursement from 2005 levels during 2006. This is, however, once again only a temporary fix and the underlying formula for calculating Medicare reimbursement has not been changed. Therefore, 2007 will see an even deeper decrease unless legislation is again introduced to change the adjustment. Surely these temporary fixes that have occurred every December for the last several years will end with some drastic solution to the formula—one that is tied to Medicare's move toward pay for performance measures.

MPM is presented to guide Medicare providers through this rapidly changing landscape. As stated by Abraham Lincoln, *"The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty, and we must rise with the occasion. As our case is new, so we must think anew and act anew."*

Be assured that *MPM* has amassed a team of innovative thinkers to help us rise to this occasion for the good of our Medicare patients.

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Reference

1. Wolff JL, Starfield B, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Arch Intern Med.* 2002;162:2269-2276.