

From the Editor

Medicare— Another Etiology for Dizziness



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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.

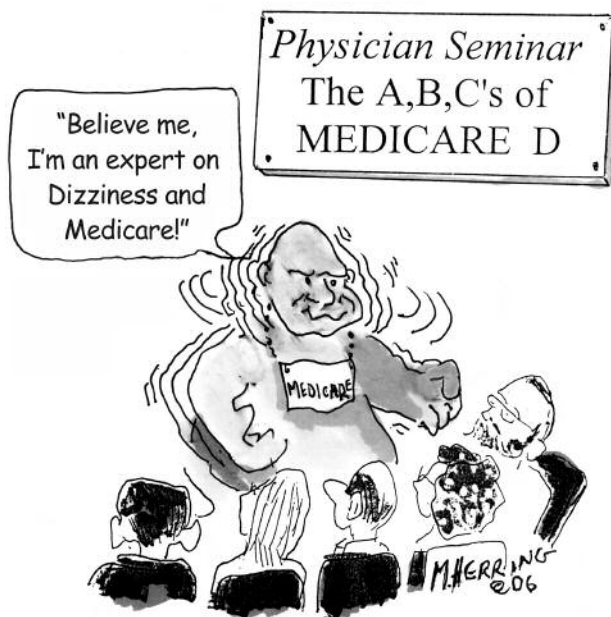
Dr. Stefanacci has a long and passionate history in long-term care (LTC). Having served as medical director for several nursing facilities and continuing care retirement communities, he is well versed in the needs of LTC facility residents. Additionally, Dr. Stefanacci's geriatric experience includes 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*.

There seems to be an increasing number of complaints of dizziness, not only from seniors, but also from the providers who care for them. Many of these cases are the direct result of the changes occurring in Medicare, especially those associated with the new prescription drug benefit available under Medicare Part D. Confusion and misinformation abound regarding this important benefit, which have been significant etiologic factors in the increase in the number and severity of dizziness cases that many are experiencing.

Another contributing factor to Medicare-related dizziness is the latest announcement from the Centers for Medicare and Medicaid Services that over 23 million Medicare beneficiaries are already receiving drug coverage from the federal government. Although this is a true statement, unfortunately it is misleading. The reason why is that among these 23 million Medicare recipients, only 3.5 million are beneficiaries who have voluntarily enrolled in the program. Thus, the initial



diagnosis shows that approximately 20 million seniors have chosen to go without drug coverage.

When these patients eventually enroll in Medicare Part D, they will be subject to a late enrollment penalty fee of 1% added to their premium for each month that they did not have drug coverage. Obviously, for younger patients, this can get to be very expensive. In addition, after May 15, 2006, these patients may find themselves locked out of prescription drug coverage until January 1, 2007. However, recent legislation may eliminate both of these adverse events, at least for the first year, by extending the initial enrollment period to December 31, 2006. Legislation to help address some of the issues that have come to light with Medicare Part D is addressed in our article, "Reading the Tea Leaves for Medicare Part D." This article was specifically written to provide a clearer understanding about the direction that this significant program is likely to take.

Another potential adverse effect of not enrolling in Medicare Part D may be the lost opportunity experienced by 1 in 3 individuals who are eligible for the Medicare low-income subsidy. The saving on medications for this group is between 83% and 100%. There are 9 million people who need to apply for this benefit through either Social Security or Medicaid to take advantage of these savings. Unfortunately,

among these 9 million potential beneficiaries, less than 1 million have been approved for the low-income subsidy, leaving some 8 million eligible patients without this significant benefit.

Besides the diffuse confusion regarding the enrollment process among patients, some providers are also experiencing difficulties in understanding how the different parts of Medicare handle coverage for prescription medications. We address this topic in the article, "Medicare Rx Coverage: The A, B, C, and Ds," which reviews the 4 different Medicare parts and how they cover prescription medications. Providers need to be clear on these differences because access to medically necessary medications can be improved by working through the correct payor channels.

And speaking of access to medications, the push by the federal government and other payors for greater use of generic drugs is sure to have far-reaching ramifications. These are addressed in the review, "Unintended Consequences: Generic Competition in the Prescription Drug Market." In their article, Drs. Blackstone and Fuhr evaluate some of the problems that could arise from the increased use of generic products.

On the provider side, the Medicare Modernization Act (MMA) certainly has left a great deal of unanswered questions when it

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Table 1.

Medicare Beneficiary Prescription Drug Coverage¹

Total Medicare beneficiaries	43,404,884
Beneficiaries voluntarily enrolling in PDPs	3,551,831
Dual eligible beneficiaries autoenrolled in PDPs	5,600,009
Beneficiaries in MA-PD	5,094,876
Beneficiaries in employer plans receiving retiree drug subsidies	6,386,690
Federal retirees (TRICARE, FEHB)	3,117,255
Beneficiaries with Medicare Part D drug coverage	23,750,661
Beneficiaries with unknown drug coverage	19,654,223

FEHB=Federal Employees Health Benefits program; MA-PD=Medicare Advantage Drug Plans; PDPs=Prescription Drug Plans; TRICARE=Department of Defense's health coverage program.

pharmacist can use, and within 3 to 4 weeks later, a drug card that also includes their billing information. It's important to tell people to hang on to that letter until they get their card. If they can wait a couple of weeks until they have an acknowledgment letter or drug card in their hand until they go to the pharmacy, they are very likely to have a much smoother transaction at the pharmacy than if they sign up for coverage or change plans at the end of the month and then try to use the coverage soon after that. We are encouraging advocates and others to let people know about this several-week period that it takes to get fully into the system. If you need drugs sooner or if there's a problem, it doesn't mean that you are not going to get your medication. It means you have to go to other systems, such as the E-1 system and the CMS help-lines available to pharmacists.

I want to thank all of you for taking the time to talk today, as we're a month into the biggest change in Medicare in 40 years. Thanks to your efforts, millions of people are getting their prescriptions filled every day. I'm impressed by the number of people served and by the number of prescriptions that are going up every day. This wouldn't be happening without you. I know there continues to be a lot of work out there for many of you dealing with these transition issues. The steps that we have been talking about are the direct result of [CMS] interactions with you.

So thank you very much for your continued leadership and all of your efforts to help everyone take advantage of the new drug coverage. The audio of this call is available on the CMS Web site [at www.cms.hhs.gov/apps/files/8105492.mp3]. You can also go to the Highlights Section [on the Web site] for more information about the announcements we've made today, as well as continuing information and updates on the prescription drug program. MPM

Reference

1. Leavitt M. Medicare Rx Prescription Drug Coverage: "Secretary's One Month Progress Report on the Medicare Prescription Drug Benefit." Available at: <http://www.hhs.gov/medicare.pdf>. Accessed February 15, 2006.

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comes to Medicare reimbursement for physicians. Under the MMA, provider reimbursement, which was expected to decrease according to the Medicare formula, instead increased by 1.5% during 2004 and 2005. Medicare normally updates the conversion factor each year through a complex formula specifically defined by federal statutes. Using this formula, the 2005 conversion factor would have decreased provider reimbursement by 3.3%. However, this cut was averted because of a Congressional mandate in the MMA that the update of the conversion factor for 2005 could not be less than 1.5%. However, this did not correct the problem of decreasing physician reimbursement, but rather delayed those cuts until 2006. Yet, once again, Congress stepped in and substituted a planned 4.4% decrease with a 0% change over 2005 reimbursement rates. So at least during 2006, the cuts that have been planned for the last 3 years have been put on hold. Given the administration's desire to cut \$36 billion from Medicare, it remains unclear how much longer physicians will have to wait until they must accept Medicare reimbursement cuts.

Hopefully, as you read this and future issues of *Medicare Patient Management*, any Medicare-related dizziness will be eased so that you will be in a better position to care for your senior patients. As the baby boomers, who include many of us, reach the age of Medicare eligibility, the numbers of senior patients will double, affecting just about every health care provider who cares for Medicare patients.



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Reference

1. The Kaiser Family Foundation. Medicare beneficiaries with creditable prescription drug coverage by type, as of January 13, 2006. Available at: <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicare&subcategory=Medicare+Drug+Benefit&topic=Medicare+Rx+Drug+Coverage>. Accessed February 20, 2006.