

From the Editor

Medicare's Cliff

This issue of *Medicare Patient Management (MPM)* is dedicated to the explanation of Medicare finances. Although this is a vitally important topic for all Medicare providers, little or no time is spent in educating ourselves about this issue. Despite our ability to make a correct diagnosis and write an appropriate treatment plan, if Medicare finances do not align with that treatment plan, it will not be carried out. Thus, nonadherence because of limited resources is a significant problem.

And what about the argument that even making the correct diagnosis and writing the appropriate treatment plan are dependent on Medicare finances? As a recent issue of *The New England Journal of Medicine* pointed out, there continues to be a wide gap between best practices and the treatment patients actually receive—a gap that can be narrowed, in part, through an investment in improved systems of care.¹

Most often, improvements in systems of care are thought of in terms of electronics, whether in the form of electronic prescribing or electronic health records. But of course, improvements in the systems of care, especially in geriatric medicine, also can be implemented through the development of an interdisciplinary team. Think of the improved



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*.



health outcomes possible for your patients if they had greater access to a dietitian or a consultant pharmacist instead. Unfortunately, the availability of these resources is dependent on how and what Medicare chooses to finance within its programs.

Even accessibility to physician services is dependent on Medicare funding. This measure, I fear, is being misread by the Medicare Payment Advisory Commission (MedPAC). MedPAC, as you will read elsewhere in this issue of *MPM*, is the nongovernmental organ-

It is MedPAC's responsibility to evaluate and ensure that Medicare beneficiaries have access to necessary physician services. The problem, I believe, is that we are finding out too late that we are heading toward a Medicare cliff, rather than a small decline.

ization that is organized to provide the federal government with data and opinions that directly affect Medicare's finances. Other measures deal directly with physician reimbursement. It is MedPAC's responsibility to evaluate and ensure that Medicare beneficiaries have access to necessary physician services. The problem, I believe, is that we are finding out too late that we are heading toward a Medicare cliff, rather than a small decline.

Of course, what I am referring to is the erosion of access to primary care physicians, as well as the limited amount of capital that these providers have to invest in the infrastructure needed to narrow the quality gap. Unless these signs are realized soon, we may find ourselves falling off the cliff, with primary care physicians exiting in great numbers and few new physicians entering this profes-

sion. This will, in fact, occur suddenly when large numbers of primary care physicians become overly frustrated by limited reimbursement and choose to opt out of Medicare, and young physicians decide to enter specialties rather than primary care where needed. Low reimbursement is especially problematic for primary care providers because, compared with procedure-based specialists, their practices tend to have lower volume growth.

Despite the fact that most parameters, including beneficiary access, physician supply, private insurer rates compared to Medicare, ambulatory care quality, and input costs, have worsened, physician reimbursement continues to decrease and the formula that produces this effect remains in place. Acknowledging both problems, MedPAC is looking into ways to adjust the formula and has gone on record as not supporting any impending fee cuts because of the threat over time to beneficiary access to physician services, especially primary care services.

So, what's the answer to the question of how to improve the quality of care in an efficient and effective manner? To answer this, we must provide incentives—both financial and otherwise—to the critical contributing factors. These include primary care providers and greater use of electronic systems, such as e-prescribing and electronic health records. If these components are not supported, we will surely find ourselves collectively falling off a large cliff that will likely harm a great many of us—providers and seniors alike.



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

Reference

1. Asch SM, Kerr EA, Keeseey J, et al. Who is at greatest risk for receiving poor-quality health care? *N Engl J Med*. 2006;354:1147-1156.