
Oh the Places You'll Go...

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O*h, the Places You'll Go!* is the title of a Dr. Seuss book, which describes the future of someone who is venturing out into the world, where he will have ups and downs, but will succeed and finally "Move Mountains!" Although I am sure the book's intent was not to describe Medicare, it can be used as an analogy to the often-unusual course that Medicare has taken its beneficiaries and providers.

Where We Thought We'd Go

Almost 20 years ago, I wrote "From Profession to Business: The Corporatizing of American Medicine," reprinted on page 10 in this issue of *MPM*. The article described what I then thought was the changing environment that health care would be operating in. I envisioned a corporatization of American medical care, where health care delivery would be divided into 3 separate and diverse markets:

- Government-funded health care based on a VA type of system, in which total care would be provided through a closed system of providers;
- A free market system, where physicians would be paid on a fee-for-service basis, with physicians and other providers opting out of insurance-based systems, instead charging patients directly; and
- A system of corporatized medical care provided through HMOs and other managed care vehicles.

Where We Went

So, where have we actually traveled over these last 20 years?

Well, while we moved aggressively into a system of corporate medicine in the late '90s, the political pressure against managed care was too strong. Because of this pressure, the gate-keeper model broke apart and reimbursement for managed care organizations was cut significantly. This resulted in managed care plans exiting the market in mass during the late '90s, only to return in the early part of 2000 as a result of Medicare's prescription drug coverage plus increased reimbursement.

Where Are We Going Now?

Now we find ourselves continuing to corporatize medical care, this time for coverage of prescription medications through Medicare Part D. In the immediate future, we are likely to follow the course laid out by the Medicare Payment Advisory Commission (MedPAC). MedPAC is an independent federal body established by the Balanced Budget Act of 1997 to advise Congress on issues affecting the Medicare program's reimbursement issues. As Medicare providers, our understanding of this organization is vital to plan

for the future. For this reason, we have reproduced the Executive Summary from MedPAC's Report to Congress, which was made public in March 2006. (See page 25 in this issue of *MPM*.) A summary of their recommendations is provided in Table 1.

Physicians are likely to continue in their struggle for reimbursement, not to increase their incomes, but to allow them the opportunity to invest capital into needed infrastructure to improve efficiencies. By investing in new technology, such as electronic health records and prescribing systems, the entire Medicare program could benefit. Unfortunately, in the current political and health care environment, physicians are finding it impossible to access the capital needed for these improvements.

Where Are We Going in the Future?

The MedPAC report points out strategies to address Medicare's long-term sustainability, which include constraining payment rates for health care providers, rationalizing benefits, increasing the program's financing, and encouraging greater efficiency from health care providers. We have already seen the constraints placed upon health care providers, as discussed in the article "Medicare Finances 101" on page 15 in this issue of *MPM*. These constraints are likely to get tighter, resulting in a greater number of providers opting out of Medicare for the private pay marketplace—an option that is dis-

Table 1.

MedPAC Recommendations to Congress on Medicare Payment Policy for Fiscal Year 2007

Service	Perceived Margins	MedPAC Recommended Change	Likely Effect
Hospital inpatient and outpatient services	Downward trend	Market basket adjustment minus half of MedPAC's expectation for productivity growth	Slight increase
Physician services	Not considered a factor	Update payments by the projected change in input prices less MedPAC's expectation for productivity growth	Zero to slight increase
Outpatient dialysis services	Positive	Update the composite rate by the projected rate in the end-stage renal disease market basket less half of MedPAC's expectation for productivity growth	Increase
Skilled nursing facility services	More than adequate	Eliminate update to payment rates	Decrease
Home health services	Good	Eliminate update to payment rates	Decrease
Long-term care hospital services	More than adequate	Eliminate update to payment rates	Decrease
Inpatient rehabilitation facility services	Positive payment rates	Eliminate update to payment rates	Decrease

cussed in the feature article “Opting Out of Medicare” on page 31.

Rationalizing benefits is likely to come in the form of limiting coverage through an increase in the age for Medicare eligibility, as well as greater restrictions on services and treatment options. In addition, increasing the program’s financing has already begun. Historically, Medicare charged the same premium for every American, regardless of their income or assets. While it can be argued that those earning more should pay more, because Medicare payroll deductions are based on wages

earned, after a Medicare beneficiary joined the program, all beneficiaries paid the same wage-based premium. Under the Medicare Modernization Act, premiums for Medicare Part B are larger for higher-income Medicare beneficiaries. Many believe that this was a test of the political feasibility of having such a differential, and that now that the test has been passed, this method of increasing the program’s financing will be applied further and deeper.

Regarding the issue of increasing efficiency, this is only possible through a substantial investment

in capital, technology, and training, which while making the most sense from a clinical perspective, is politically impossible. We will make some attempts in this direction through pay-for-performance measures that provide capital to practices utilizing electronic health records and prescribing systems. Politically, however, it is going to be difficult, if not impossible, to pass legislation that, on the one hand, provides more capital to Medicare providers while, on the other hand, asks Medicare beneficiaries to pay more for less.

In the end, I still believe the predictions that I made some 20 years ago—that American medicine will be provided in 1 of 3 environments: government-controlled health care, corporatized medical practices, or private fee-for-service systems. Only now I believe that given the wealth available to seniors and an increased awareness of the importance of good health, a greater amount of care for Medicare beneficiaries will take place outside of Medicare through private fee-for-service providers.

The nice thing about predictions is that you can always look back to see how well you guessed the future. I look forward to republishing a similar article in *MPM* 20 years from now, at which point I will be even more invested into Medicare as a new Medicare beneficiary...oh, it certainly will be interesting to see the places we will go! *MPM*

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