From the Editor

Getting Value

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.*

Quality is something that we all look to produce and to receive from everything we do. But what does quality mean to Medicare, and how does this powerful organization obtain quality? In the world of health care, value is most often based on 3 factors:

- Access
- Quality
- Cost

Historically, cost has been Medicare's primary focus. In their latest report, the Medicare Payment Advisory Commission (MedPAC), the nongovernmental organization that advises Congress on issues affecting Medicare, points out that, "Controlling spending is essential to assure the sustainability of the program [Medicare]."[1] However, the problem with this statement is that it is not "controlled spending" that is needed, but rather "smart spending." Spending on necessities to obtain quality outcomes should never be considered an issue. Yet, in the push to control spending, we are likely to enter an area of cuts into utilization that will adversely affect quality. Furthermore, access to quality health services will, in all probability, be affected as well.

The proposed cuts in Medicare reimbursement to physicians could lead to a shortage of health care providers as they are forced to exit a low reimbursement environment. As noted in *Medicare Patient Management* (MPM) and reported elsewhere, the net income of primary care physicians has decreased by 10% over the last decade. Given the federal focus on controlled spending, any increase to improve the access to and quality of physicians' services is highly unlikely. In fact, the Centers for Medicare and Medicaid Services' (CMS') estimate for 2007 physician reimbursement is set at a negative 5%, which is the maximum negative update permitted under the Medicare reimbursement formula defined by statute. This is a continuation of the trend of consecutive reimbursement cuts that Congress has overridden every year since 2002, which have resulted in no change or only slight increases in reimbursement

payments for physician services.

Although Congress could again move to a zero or slight increase in reimbursement, further delay in implementing the formulated reduction is unlikely for providers who report quality data as part of Medicare's move toward a pay-for-performance system. This would simply follow the pattern established by Medicare for hospital reimbursement payments, moving from a system of voluntary quality data reporting, which few hospitals complied with, to a system that ties the reporting of quality data to reimbursement increases. Given the ongoing failure of physicians to voluntarily report quality data, they should be prepared to submit their quality data sooner than later.

The other issue raised by MedPAC's report that touches a nerve in most physicians is that of accountability for providing quality care. No physician ever graduated from medical school saying to themselves, "I'm going to do a really bad job caring for patients." Yet unfortunately, this is how many key opinion leaders view our world. They believe that since physicians are not paid to produce quality, they are not driven in that direction. While the first part of that statement is true, the conclusion is faulty. Physicians are not, in fact, currently paid more for producing improved quality outcomes. However, this does not mean that as a profession, physicians are not driven to achieve that goal. Instead of trying to change the system on the basis of this faulty belief, resources should be made available to encourage higher quality outcomes through the use of electronic medical records systems and care coordination teams.

This issue of MPM focuses on the big picture of "quality" in the Medicare program in the broadest sense, as well as in a seasonal example of quality care. One article examines Medicare's pursuit of quality in the past and considers where its quest will likely take us during the next few years. Another article on Medicare's Quality Improvement Organization (QIO) Program describes how these organizations can work with providers to deliver "the right care for every person every time." Lastly, we look at the quality of infectious disease prevention services for seniors.

In our continuing efforts to provide quality to our readers, MPM is launching new components to its pages. ACE (Acute Care for the Elderly) Cards—geriatric clinical reminder cards developed by Dr. Michael Malone and his colleagues as a quick reference to help busy clinicians manage common senior conditions—will be highlighted in the Case Study section of each issue. ACE Cards, like the Beers Criteria, are evidence-based resources that improve the quality of services delivered to Medicare patients.

I would also like to take this opportunity to call attention to 2 individuals with ties to MPM, who in no small way have been responsible for the push for quality outcomes,

MPM Editorial Advisory Board Member to Become AARP President

MPM's Editorial Advisory Board Member Jennie Chin Hansen, RN, MS, FAAN, of San Francisco, CA, has been elected as the American Association for Retired People (AARP) President-elect for the 2006-2008 biennium and will automatically succeed as AARP President in 2008. Ms. Hansen makes this transition after nearly 25 years as Executive Director of On Lok, Inc., a nonprofit family of organizations providing integrated and comprehensive primary care, long-term care, and community-based services in San Francisco. On Lok is the prototype for the Program of All-Inclusive Care for the Elderly (PACE), which was signed into federal legislation in 1997. Currently, Ms. Hansen serves in various leadership roles, including Commissioner of the Medicare Payment Advisory Committee (MedPAC). MPM congratulates Ms. Hansen on her latest prestigious appointment and is proud of her active role on our Editorial Advisory Board.

"Hold still! Medicare's Accountability Team is doing a QA assessment!"

and who are making major shifts in their personal careers.

Dr. Mark McClellan, who has led CMS during the implementation of Medicare's modernization, left his post to return to teaching. In his resignation letter, Dr. McClellan called this "one of the most important and transformational times our agency has ever experienced," noting that this was in part because of the move in Medicare's focus to preventive and quality care issues. No replacement has been named. Deputy Administrator Leslie V. Norwalk will serve as Acting Administrator.

The other individual who has been a major force in the push toward quality is Jennie Chin Hansen, RN, MS, FAAN. In addition to serving on MPM's Editorial Advisory Board, Jennie recently became President-elect for the 2006-2008 biennium of the American Association for Retired People (AARP), and is automatically set to become the President of AARP in 2008. This honor coincides with the next presidential election, which is likely to result in further transformation of Medicare, as cost concerns and the push for quality become an even greater focus.

Although we all cannot lead such powerful organizations as CMS or AARP, each of us can, in our own way, push for improved quality outcomes for the seniors we care for, just as we do as providers of content or readers of MPM. MPM

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Reference

1. Medicare Payment Advisory Committee (MedPAC). *Report to the Congress: Increasing the Value of Medicare.* Washington, DC: MedPAC; June 2006. Available at: http://www.medpac.gov. Accessed October 7, 2006.

MPM's Provider Action Plans

Yet another move toward quality improvement can be seen in MPM's new Provider Action Plans. These plans, which appear at the end of each feature, will replace the "Take-Away Messages," which summarized the main points of each article and provided information on the Return on Investment (ROI), highlighting the main points that could impact you as a provider. Medicare recently introduced a similar summary of key messages to providers, using traffic light icons to alert readers to important messages in a succinct and simple way. In a similar manner, MPM'S Provider Action Plans are designed to describe when providers should:

- **Stop–Impact to You**
- **Take caution–What You Need to Know**
- **Go–What You Need to Do**

These sections can be used as a starting point for approaching the MPM features. After quickly reading the Provider Action Plan, read the entire article in detail and then develop your own personal action plan based on what you've just read in the context of your individual situation.