

From the Editor

Beyond 2007: A Very Different Medicare



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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 an 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*, *The Journal of Quality Healthcare*, and *Assisted Living Consult*.

As we enter a new year, much has changed. Medicare Part D is now 1 year old, and new leadership has taken over both the House and the Senate. This leadership is expected to swiftly move for change and greater oversight of the Medicare program. The views of the new leadership in Congress are philosophically very different from those of the Republican leaders. Instead of pushing for Medicare to move toward a welfare program, the Democratic leadership believes that fee-for-service Medicare should be re-enforced as a strong entitlement program. They also believe that to become a stronger program, Medicare will require greater funding.

Each part of the Medicare program is anticipated to change, as are some of the programs that compete with Medicare. Such programs as Health Savings Accounts and consumer-driven health plans will meet with less-than-enthusiastic support from the Democratic Congress. The issues that are prompting a review of Medicare are safety and reimbursement of physicians and drugs.

Safety Issues

The authors of a recent study¹ published in *Pharmacotherapy* analyzed 565 consecutive adult medication-related hospitalizations over a 12-week period. The frequency of such inpatient stays was 24.1%, of which 72.1% were deemed preventable. The severity of the hospitalizations was stratified as mild (8.1%), moderate (83.8%), severe (7.4%), and fatal (0.7%). The most common classifications of drug-related hospitalization were adverse drug reactions (35.3%), improper drug selection (17.6%), and noncompliance (16.2%).

In addition to these medication safety concerns that are the focus of pay-for-performance and other initiatives, there is continued focus on funding for physicians and pharmaceuticals. The problem is especially acute in the Medicare Part D program and the "donut hole." (See "Managing the Donut Hole" on page 22.)

Physician Reimbursement

Direction for changes to Medicare Part B will come mainly from the Medicare Payment Advisory Commission (MedPAC). These recommendations will fo-

cus on changes to the sustainable growth rate (SGR) system, thus ensuring what is hoped to be a more appropriate standard for reimbursement. However, even if these changes are approved, they are unlikely to reverse the trend of stagnant reimbursement to physicians that has occurred over the last several years.

While the Centers for Medicare and Medicaid Systems (CMS) has released its final physician fee schedule ruling, calling for higher payments for evaluation and management services, it has also requested a fee cut of more than 5%.² The effect of such a cut would be to negate the evaluation and management payment increases. CMS projects that it will pay approximately \$61.5 billion to more than 900,000 physicians and other healthcare professionals in 2007.² This figure includes the 5.1% decrease, which if held to 0%, would mean an additional \$3.13 billion in CMS spending.

The new Congress will likely re-evaluate the SGR formula based on MedPAC's recommendations. In the meantime, it is also likely that, just as last year, the Congress will zero-out any changes in the fee schedule for 2007. If this prediction is correct, the elimination of the fee schedule reduction would be funded by elimination of the \$10 billion 10-year Medicare Advantage stabilization fund. Physicians will likely need to report their quality data in 2007 (which was voluntary in 2006) to avoid the decrease in rate.

The need to invest in health information systems is increasingly recognized, as is the need for the necessary capital to come from the Federal government rather than providers themselves. Such funding will likely be spread over a 5-year period with the hope that the increased reimbursement to providers focuses on office visits rather than procedures.

Pharmaceutical Reimbursement

The new Congress is anxious to attack the donut hole with one of three approaches. In the middle of the spectrum, and the most likely to be passed, is a plan wherein the Secretary of the US Department of Health and Human Services (DHHS) would negotiate ceiling prices for drugs that would then be passed on to prescription plans. Of course the question is: On what criteria would these prices be based? At the one end of the spectrum is a plan to simply remove the noninterference clause that currently prevents the DHSS Secretary from interfering in negotiations be-

tween drug manufacturers, pharmacies, and prescription-drug plan sponsors. This plan may not require a particular formulary, or institute a price structure for Part D drugs. However, simply removing the noninterference statement is unlikely to result in changes by the current DHHS secretary. At the far end of the spectrum is a plan that mandates the Federal government to set a national formulary. But, how would this formulary be set? One thing is clear: we are moving toward greater restrictions on access to medications.

MPM's Action Plan

With major changes in physician reimbursement and pharmaceutical access occurring around us, *Medicare Patient Management (MPM)* will work to keep you ahead of the curve. Of course, the key to determining the future model of care delivery is to follow the money. This is exactly what we have done in this issue with such articles as "Importing the Canadian Healthcare System" (see page 32) and "Health Saving Accounts (page 37). Plus, we've shown you such innovative models of care as concierge medical practices. (See "Concierge Medicine: Origins, Growth, Controversies, and Implications to Medicare," page 26).

Besides focusing on these critical issues, we have also made it simple for you to stay in focus by including an action plan for each article that describes *Impact to*

You, What You Need to Know, and What You Need to Do. We hope these insights help you proactively develop your practice for continued success. **MPM**

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References

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2. Centers for Medicare and Medicaid Services (CMS) Office of Public Affairs. Medicare announces final rule setting physician payment rates and policies [press release]. Baltimore, MD: CMS. November 1, 2006. Available at: www.cms.hhs.gov/apps/media/press/release.asp?Counter=2044. Accessed December 4, 2006.



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