

From the Editor

Consumer-driven Primary Health Care

Is acceptance of consumer-driven health care as slow paced as it seems or are we interpreting the wrong measures of its growth? All too often success of consumer-driven health care is measured by the number of enrollees in health savings accounts (HSAs), flexible savings accounts (FSAs), and other similar products. Instead, we should focus on new consumer-driven primary care products and services to measure growth and acceptance.

Consumer-driven care is markedly different from government-regulated health care, which is dictated by price controls and regulatory oversight of quality. In government-regulated markets, mediocrity results. Take, for example, the current market for Medicare primary care. Governmental price controls and underpayments to physicians have resulted in minimum services and access. If Medicare providers were paid appropriately for their services, they would be more likely to invest in technology and increase care access for patients. The lack of adequate reimbursement is the reason why few physician practices have electronic medical records systems or offer Sunday office hours despite the attractiveness of this latter feature to patients.

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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 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*.



Today we are moving beyond bricks and mortar to consumer-driven primary care services in less traditional venues. Nurse practitioners now run accessible, nonemergency care centers across the country. The number of AL facilities is surpassing the number of SNF beds. Concierge medical practices are attracting more and more patients, and preventive health centers are garnering consumer interest nationally. These are examples of market response to what consumers want in health care—superior quality and accessibility at a fee they are willing to pay privately.

Convenient Care

Responding to consumer needs is the Convenient Care Association (www.convenientcareassociation.org), which operates small healthcare facilities with pharmacies, typically located in high-traffic retail outlets, that provide affordable and accessible, non-emergency health care. Called convenient care centers (CCCs), these facilities are often open 7 days a week and are designed to complement traditional medical services. Nurse practitioners with advanced education provide health care for common episodic ailments (eg, colds, flu, skin rashes, sprains, etc.), immunizations, physicals, and preventive health screenings.

Preventive Care

Another consumer-driven model is that of US Preventive Medicine (www.uspreventivemedicine.com). A nationwide network of self-pay preventive health centers (branded The Center for Preventive Medicine®) offers patients what it terms a “5-star” customer experience customized for each consumer’s medical needs. Customers can participate in a day-long prevention program in state-of-the-art medical facilities with advanced imaging and diagnostic technologies. Tests are run and a staff physician then provides extensive consultation on results, implications, and recommendations for health management or appropriate interventions. Customers are given the results and recommendations on a USB drive to take home with them and share with their PCPs. The philosophy is that the patient’s PCP can now easily have a comprehensive assessment and record of the patient’s current state of health and risk factors. Through a voucher system, most US Preventive Medicine programs compensate PCPs for reviewing the patient’s results, discussing their significance, and developing management or intervention plans.

The Center for Preventive Medicine does not accept insurance as payment because it views the health insur-

Continued cuts in Medicare physician reimbursement and implementation of state taxes on physician revenue (as in California) threaten to prevent primary care physicians from maintaining their practices while delivering traditional fee-for-service Medicare.

The pressure to decrease physician Medicare reimbursement continues. This year, plans were to decrease Medicare reimbursements by 5.1%. However, Congress held the change to 0%. But the adjustment added an additional \$3.13 billion in spending by the Centers for Medicare and Medicaid Services (CMS). Physician office expenses, including staff and malpractice and health insurance costs, exceed the rate of inflation; thus, yearly adjustments have resulted in a significant cut in Medicare provider reimbursement. Next year, a 10% cut is planned based on the sustainable growth rate (SGR) formula. The planned cut is currently being reevaluated because of its effect on Medicare beneficiary access. The effects of these trends are to move primary health care from traditional primary care physician (PCP) offices to consumer-driven primary healthcare models.

Consumer-driven care is not new, however. Consumers have been demanding more from their healthcare providers, pushing them in free-market directions. Think for a moment about those areas in which the free market has been allowed to develop: the growth of assisted living (AL) is a direct result of seniors’ demands for an alternative to traditional skilled nursing facilities (SNFs).

ance industry as a disease-oriented system, providing reimbursement only after diseases become symptomatic. Preventive medical care has not been valued in the health insurance model, and reimbursement is variable. In most cases, however, the services of the Center for Preventive Medicine qualify for reimbursement by consumer-driven health plans such as HSAs, FSAs, and some preventive benefit components of insurance plans.

The Future of Primary Care Medicare

Consumers are pushing primary care toward high quality and convenient access. Forward-looking companies like the Convenient Care Association and the Center for Preventive Medicine are among the first to hear consumers' calls and answer them. Clearly Medicare primary care will need to respond to these changes in the marketplace by either adapting to what consumers want or ceasing to exist as we know it.

In this issue of *Medicare Patient Management*, we focus on many of these changes in consumer-driven health care and provide insights to help you take advantage of the shift in the Medicare marketplace—a shift that is likely to increase in magnitude once the full force of the baby boomers' will is felt. The real question is: Are you ready for the change?



Richard G. Stefanacci,
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Letters

Dear Sir,

Your smile in your editorial is not reflected by primary care physicians. A 35% cut in CMS reimbursement over 7 years, on top of flat reimbursement of the past 5 years is no laughing matter.

Your magazine has several overly optimistic articles that don't reflect the reality of the upcoming challenges facing patients and doctors alike. Empower physicians to end the terrific waste of money in the last 30 days of life spent on needless MRIs, unlikely-to-succeed hospital treatments, and silly invasive interventions, and Medicare could remain solvent.

Please show some leadership. 1) Don't support CMS in its effort to squeeze out all primary care MDs (truck driving schools are already full!). 2) Do support efforts at reducing wasteful spending in the last 30 days of life. 3) Empower primary care physicians to direct reasonable care.

Thanks,
Dr. Traub, MD, FACP
Rapid City, SD

Editor's Note:

Dr. Traub's letter inspired us to "Ask the Experts" to offer their suggestions about efficient and effective management of care at the end of life. Read the comments of our expert panel starting on page 35.

30% or 80%? *How many of YOUR patients are Medicare beneficiaries?*

Cardiology, Endocrinology,
Family Medicine or
Geriatric Medicine?

Which best describes
YOUR practice?

Alzheimer's disease,
Congestive Heart Failure,
Insomnia, Pain Management?

What conditions do patients in
YOUR practice represent?

How much we know about **YOUR PRACTICE**, informs our delivery of information you can use.

Please take our 2 minute **SURVEY** to tell us about **YOUR PRACTICE**.

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