From the Editor

The Rapidly Changing Face of 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.*

Medicare, the program that has been the foundation for senior care in the United States since 1965, is undergoing rapid changes—changes regarding who the Medicare beneficiary is, what services are available, and how those services are being paid. This issue of *MPM* addresses many of these transformations and points out how to take advantage of the opportunities that may become available.

To start, the number and demographics of Medicare patients are evolving. These changes, described in detail by the Medicare Payment Advisory Commission (MedPAC; www.MedPAC.gov), will have a major impact on how physicians practice, starting with the number of senior patients at their doors. The unprecedented increase in the number of Medicare beneficiaries, occurring as baby boomers age, places greater demand on all physician services, especially primary care. Physicians may be prompted to consider group visits, telemedicine, and "just in time" appointments as ways to deal most efficiently with the growing demand for their time. They may also wish to consider working in long-term care (LTC) as salaried facility-based physicians, especially in the face of increasing fiscal pressures in office-based practices.

Elders have growing needs for LTC services, as MedPAC pointed out, in part because adult children are becoming a less reliable source of custodial care for their parents. While historically in countries like Japan families were the primary caregivers for their elderly family members, this is increasingly not the case in the US. There is a shift in the US away from family-oriented assistance, increasing the use of different forms of LTC such as homecare services, adult day care, and assisted living (AL).

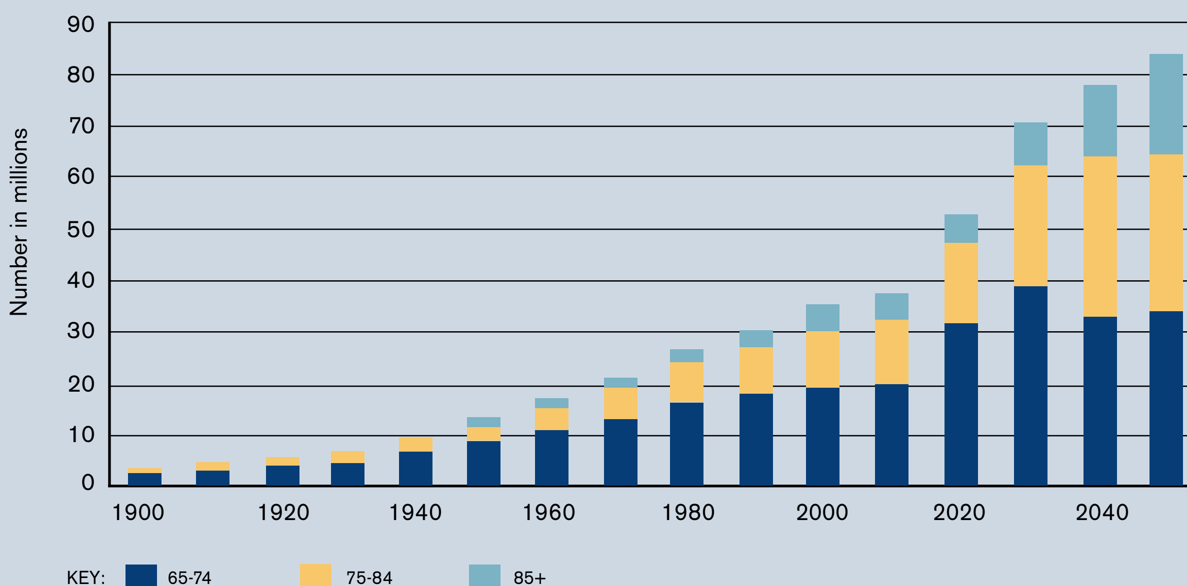
The profile of beneficiaries is changing as well. More and more patients, with longer life expectancy, are being treated for several chronic conditions, while at the same time, the proportion of beneficiaries who are disabled is declining. Medicare has already responded to these changes by increasing the range of preventive services available to Medicare beneficiaries. Combined with the move toward pay-for-performance, this change will increase the attention paid to preventing the progression of chronic conditions. Management of these comorbid

chronic conditions also requires an interdisciplinary care-team approach. Medicare continues to focus attention on care coordination and is looking at penalizing hospitals for readmissions that occur within 30 days for the same diagnosis or complication. This tactic will force hospitals to pay more careful attention to discharge planning, including physician follow-up visits.

The decline in employer-sponsored insurance creates a greater reliance on federal and state programs at a time when these programs are stressed beyond capacity. As is pointed out in *Medicare's Quagmire* on page 22 of this issue, Medicare is striving to balance costs and quality. While some of the costs will be shifted to beneficiaries through increased premiums, the greater burden for these necessary cost reductions will be placed on providers. As a result, providers will be forced to do more with less, meaning they will need to find new ways to practice, develop methods to reduce office overhead, or opt out of Medicare completely by entering concierge-type practices.

It's especially interesting that the article ends with Ault's conclusion that the success of these measures (referring to quality outcome measures) remains to be seen. Just recently in *The Wall Street Journal,* that specific point was addressed in an examination of the pay-for-performance program in hospitals. This is especially timely given the recent introduction of the Physicians Quality Reporting Initiative (PQRI), Medicare's first pay-for-performance program for providers. In its reporting, *The Wall Street Journal* pulled from the Duke study published in *JAMA,* the findings of which showed that the PQRI was not associated with a significant incremental improvement in quality of care or outcomes for acute myocardial infarction. Obviously these findings call into question the effec-

Figure 1. Growth of US Older Population



Source: http://usgovinfo.about.com/cs/healthmedical/a/aasickboomers.htm

Richard Glew Stefanacci

September 27th 1992 - June 12th 2007

Richard Glew Stefanacci, of Merchantville, NJ, spirited soul of his parents Beth and Richard; loving brother to Christopher, Morgan, and Nicholas; and friend to many—especially at Camden Catholic High School, St. Peters School and parish, and Camp Woodward—passed away at the young age of 14 after a year-plus battle with Ewing Sarcoma. His challenging year with cancer is detailed at: www.goforthegoal.com.

In thinking of Richard, words that come to mind are Happy, Spirited, Soulful, Extreme, Friend, Teacher, Surfer, Inliner, Snowboarder, Rock n Roller, Traveler, Philly, and Smile.

Richard has always given his all to friends, family, and strangers and continues to do so in dying. He still leads us as he donates his corneas. Unfortunately, because of Richard's disease, these were all that he could give.

In lieu of any gifts, please consider a donation to Go4theGoal Foundation at: www.goforthegoal.com. This foundation will continue to be guided by Richard's spirit—in a way that only Richard could lead us in caring for children affected by cancer.

tiveness of PQRI, especially given the high amount of physician work involved in the program for a small return of 1.5% in Medicare reimbursement.

These changes in health care will mean 2 things: practitioners will be adjusting their practices and Medicare will be making some major changes. MedPAC has outlined 5 areas of focus to better accommodate the changing Medicare beneficiary demographics and the need to reduce PQRI program costs. These measures focus around improvements in the following:

1. Care coordination
2. Healthcare information technology
3. Comparative effectiveness analyses
4. Promotion of lifestyle changes
5. Restructuring of benefits and cost sharing

Even before these recommendations were announced by MedPAC in April, President Bush had already signed an executive order that went into effect January 1, 2007. This executive order focused on expanding the use of health information technology, increasing the transparency of quality and price, and improving the incentives for beneficiaries and providers. Although the PQRI, which began July 1, is the first response to this executive act, more will clearly be coming soon.

Of course a critical question regarding all of these changes with Medicare is how exactly the agency will face these new challenges with increasingly limited resources. Already Medicare is looking at a 10% decrease in reimbursement to physicians for 2008. Physicians have responded in a recent American Medical Association (AMA) survey of nearly 9000 members who state that if the decrease in reimbursement occurs, 60% will limit the number of new Medicare patients they accept. As discussed in a previous issue of *MPM*, it appears we are getting to that tipping point at which access to physician services becomes problematic under the Medicare system.

So what are practitioners to do about the changing face of Medicare? Practitioners need to work on 2 fronts. First they must make their practices more efficient and effective in delivering outcomes that matter most. Second, there must be attention paid to state and federal legislation. Clearly how we practice medicine today is increasingly dictated by legislative decisions. These legislators must be informed by clinical leaders about what is needed to deliver quality care. MPM

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