

# From the Editor

## Armed with Knowledge



**Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD**

As the executive director of the Center for Medicare Medication Management (cm<sup>2</sup>) at the University of the Sciences in Philadelphia (USP), Dr. Stefanacci is currently creating a LTC Management Degree Program for undergraduate and graduate students. He continues to build on his work as Health Policy Scholar at the Center for Medicare and Medicaid Services (CMS), where he helped develop and implement the Medicare Part D Pharmacy Benefit.

As a geriatrician, Dr. Stefanacci has worked in LTC for decades as medical director for several nursing facilities and continuing care retirement communities. He has also served as a medical director for primary care private practices, full-risk provider groups, Medicare + Choice HMO (M+C) programs, and the PACE (Program for All-inclusive Care for the Elderly) program in Philadelphia. Dr. Stefanacci provides direct patient care for the St. Agnes LIFE program and works with Newcourtland on innovative LTC services such as electronic dispensing and prescribing systems for the company's facilities. He also serves as executive director of HepTREC, the Delaware Valley Hepatitis Treatment, Research and Education Center.

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 earned a fellowship in Geriatrics at the same institution.

Dr. Stefanacci participates actively in the American Medical Directors Association (AMDA), Academy of Managed Care Pharmacy, American Society of Consultant Pharmacists (ASCP), and the American Geriatrics Society (AGS). He is a fellow in both the College of Physicians of Philadelphia and AGS and an honorary lifetime member of ASCP. He is editor-in-chief of *Assisted Living Consult* and *Medicare Patient Management* and serves on the editorial boards of *Consultant Pharmacist*, *American Psychiatry News*, *LTC Interface*, *Managed Care*, and *Jefferson's Health Policy Newsletter*.

Dr. Stefanacci's proudest accomplishment is as founder and member of the board of directors of [www.Go4TheGoal.org](http://www.Go4TheGoal.org).

We cannot turn on the TV, open a newspaper, or listen to the radio without being hit with Presidential politics. While we all certainly have an opinion on which candidate we prefer, oftentimes these decisions are based on rather superficial appearances rather than the effect that the candidate's healthcare policies will have on the health of older adults. *Medicare Patient Management* does not plan to endorse a candidate but rather to provide knowledge to help our readers make well-thought-out decisions on their own.

In this issue of *MPM*, a significant portion of content is dedicated to this effort. The Kaiser Family Foundation has developed one of the finest summaries that explains how Medicare is financed: the article describes the program's long-term financing situation from several perspectives and reviews the factors that contribute to Medicare's financial challenges. This information is essential for evaluating the different Presidential candidates' positions regarding caring for older adults. Even more important than evaluating a Presidential candidates' position on health care, perhaps, is to develop one's own personal strategy for dealing with these coming changes.

### Filling Medicare's Shortfall

One of the biggest issues to examine is the bankruptcy of Medicare. You will learn in this issue that Medicare cannot truly go bankrupt, but a shortfall will exist with all of the Medicare funds. And this shortfall will occur prior to me (or maybe you) reaching Medicare eligibility age. To avert this shortfall, the next president will be forced to make decisions that may include approaches designed to slow overall growth in healthcare costs, including creating and disseminating more information about the comparative effectiveness of alternative medical treatments and linking these findings to payment policy, changing the financial incentives of healthcare providers by bundling payments, and increasing patient cost sharing.

Even today Medicare has been attempting to control expenditures through a series of reductions in physician reimbursement. Despite this plan, which is based on the sustainable growth rate (SGR) calculation, Congress has stepped in to add a slight increase or hold to zero any planned reduction in provider reimbursement. To-

day the immediate concern is that the Medicare physician reimbursement fix that was introduced the beginning of this year is scheduled to expire in just a few months. Without action by Congress, Medicare reimbursement will be cut back as originally proposed by CMS. More on this to come....

Besides the changes made to physician reimbursement, major changes are occurring regarding hospital reimbursement. The Centers for Medicare and Medicaid Services (CMS) has selected 8 conditions impacting the fiscal year 2008 Inpatient Prospective Payment System (IPPS) as follows:

- Object left in during surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Pressure ulcers
- Vascular catheter-associated infections
- Surgical site infection—mediastinitis after coronary artery bypass graft
- Falls and trauma—fractures, dislocations, intracranial injuries, crushing injuries, and burns

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The IPPS Final Rule now requires hospitals to document that the above conditions must be on the Present on Admission (POA) form to receive a DRG (diagnosis-related group) payment, which includes a higher amount for complicating condition (CC) or major complicating condition (MCC).

Hospitals were required to begin documenting POA

conditions on October 1, 2007, with a grace period through April 1, 2008. At that time, CMS will begin returning claims if POA coding information is missing. Beginning October 1, 2008, CMS will no longer reimburse for hospital-acquired conditions that are not documented as present on admission. Obviously this will have an impact on those practicing within the hospital setting.

### **Moving Away From Medicare**

Although hospitals are not in a position to move away from Medicare reimbursement, they must conform to the changes in the rules. Physicians are in a more flexible position with several options worth reviewing when it comes to Medicare.<sup>1</sup>

### **PAR**

Participating physicians (PAR) agree to accept what Medicare allows for payment for each service as payment in full for all of their Medicare patients. Medicare payments to PAR physicians come in the form of a 20% copayment from the patient either directly or through the patient's secondary insurer and a direct 80% payment from Medicare. PAR physicians are not permitted to bill patients above the Medicare allowable rate. Although PAR physicians are required to bill all their patients in this same manner, they are not required to accept all Medicare beneficiaries into their practice.

Medicare considers participation by physicians to be very important since access to services is one of the measures that is monitored closely. Besides adjustments to the fee schedule to encourage or maintain participation, Medicare also provides other incentives for PAR physicians. These incentives include the following:

- PAR physicians receive a 5% higher rate than non-PAR physicians from Medicare.
- These physicians—unlike those that are non-PAR or private—are included in physician directories provided to Medicare beneficiaries to aid them in selection of a physician.
- A toll-free claims processing line is available only for PAR physicians to aid in processing of their claims.

### **Non-PAR**

Decisions can be made on an individual patient's basis for those physicians choosing to be non-PAR physicians with Medicare. These physicians can bill patients above the Medicare allowance for unassigned claims.

Medicare pays non-PAR physicians based on a fee

## The Health Care Genie



schedule that is set at 95% of the Medicare allowable amount. Non-PAR physicians are then allowed to directly charge their patients above this amount, although these charges cannot exceed 115% of the Medicare-approved amount. This is not a true 15% difference from that available to PAR physicians because PAR physicians are already receiving a 5% higher rate than non-PAR physicians. As a result, the actual difference collected by non-PAR physicians is 9.25% over that of PAR physicians. Of course this additional 9.25% does have some costs associated with it. These costs include collecting these extra fees from patients, which translates to bill handling and bad debt expenses.

Within non-PAR, there are two options for physicians to choose: to be assigned or nonassigned. Assigned non-PAR physicians accept payment from Medicare directly but forgo the opportunity to bill patients over the 95% Medicare allowable. Physicians who choose to be non-PAR unassigned can bill at 115% of the Medicare-allowable rate with Medicare paying 80%, but this reimbursement is paid to the patient who then is responsible for paying the physician.

### Private Contracts

Billing the patient directly without involvement of Medicare is possible for those who opt completely out of Medicare, becoming private physicians. Private

physicians forgo all payments from Medicare. Only 3% of physicians with practices open to private patients have completely closed their practice to new Medicare patients. The top reasons cited by those who have closed their practices to Medicare patients are inadequate reimbursement, billing and paperwork, high clinical burden, and simply being too full.

The process of becoming an opt-out physician requires the physician to sign and submit an affidavit stating that he or she agrees to forego Medicare payments—either directly or indirectly—for a period of 2 years. Private physicians are also required to have a written agreement with each patient. This agreement must be signed by the beneficiary before any services are rendered and never during an emergent or urgent situation. In addition, the patient agreement must state that the patient is responsible for all of the physician's charges and is unable to submit any claims to Medicare or a Medigap policy. In addition, the patient acknowledges that he or she has the option to receive the same services for a 20% copayment of the Medicare allowable reimbursement by visiting a PAR physician.

### Knowledge is Power

Recently I received a letter that stated that “education is the center of this issue,” which I cannot agree with more. After all knowledge is power—and when it comes to being a Medicare provider, that knowledge requirement for being a successful clinician goes beyond simply making the correct diagnosis and ordering up the most appropriate treatment plan. Now more than ever, that knowledge requires a clear understanding of Medicare. Where Medicare stands today and where Medicare is moving are not easy questions to answer, but clearly they are more likely to be answered correctly if Medicare clinicians are armed with knowledge. This issue and every issue of *MPM* works to provide that vital resource!

*MPM*

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1. Stefanacci RG. Opting out of Medicare. *Medicare Patient Management*. 2006;1(3):32-35.