

# From the Editor

## Improving Quality, Cost, and Access: Focus on Efficiency



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Dr. Stefanacci continues to build on his work as the 2003-2004 Health Policy Scholar at the Centers for Medicare & Medicaid Services (CMS), where he helped develop and implement the Medicare Part D Pharmacy Benefit. He is currently creating a LTC Management Degree Program for undergraduate and graduate students in the Geriatric Health Program, Center for Medicare Medication Management (cm<sup>3</sup>), Mayes College, University of the Sciences in Philadelphia (USP).

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).

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The million-dollar question or, rather, trillion-dollar question for this presidential season is how does one deliver higher quality health care at a lower cost. Many of the proposed changes to our healthcare system would actually move costs upward. There are few good ways to reduce costs. The easiest way to decrease cost to patients is by having someone else foot the bill, like the government—at either the state or federal level. Of course, this doesn't really lower the cost of health care; rather, it simply shifts it from the patient to the government.

One way to lower costs is to force providers of care to accept lower reimbursement for their services. This is the current approach of the Centers for Medicare & Medicaid Services (CMS), but a dangerous one, since it has produced a shortage of the very type of physicians that most other countries rely on to improve care at lower costs—primary care providers. Proposed further cuts, such as CMS' pending 10%+ cut, would put even greater restrictions on patient access to these important managers of care. Given that providers frequently close their doors to new Medicare patients, this may be a very difficult course to travel.

Another way to decrease total healthcare costs, which is more politically suicidal, is the "R" word—*rationing*. Given the pushback from the public to the managed-care gatekeeper approach, the likelihood of deeper restrictions on access of care is remote.

The Holy Grail of cost reductions is increasing the efficiency of the healthcare system. Despite lots of talk in this area, little has occurred. Such innovative systems as electronic health records (EHRs) and e-prescribing have been talked about for some time with little traction. However, the market is pushing other efficiencies, such as increased use of physician assistants and nurse practitioners, convenient care clinics, case management, and improvements in transitions of care.

### Efficient Options

An examination of some of the options in controlling costs and their effects on both patient costs and total costs is outlined in Table 1. These tactics are really shifting of expenses. However, a few focus on waste reduc-

**Table 1. Cost Control Options**

How	Patient Cost	Total Cost
Government pays the bill	Reduced	Increased because of moral hazard and increased coverage
Price controls	Increased; because of reduced access, especially in primary care, total health expenditures could increase.	Increased; because of reduced access, especially in primary care, total health expenditures could increase.
Waste reduction	Reduced	Reduced
Improved malpractice system	Reduced	Reduced
Increased efficiency	Reduced	Reduced
Mandatory coverage	Increased	Depends on who pays the bill
Benefit requirements	Increased	Depends on who pays the bill
Patient cost shifting (co-payments, tiering)	Increased However, cost shifting may force underutilization, especially of necessary preventive care.	Decreased

**Table 2. Redesigning the System**

Touch Point	Traditional	Redesigned
Initial contact	Yellow pages	Google/referral portal
Preregistration	Mail or waiting room	Online or onsite kiosk
Appointment reminder	Mail	Phone/e-mail reminder
Visit history	Nurse	Kiosk
Ask nurse a question	Telephone	Secure communication
Appointment	Telephone	Online
Prescription renewal	Telephone	Online
Personal health record	Medical records request	Patient portal
Patient education	Hodgepodge	Web site
Patient payment	Mail/manual follow-up	Online
Lab results	Nurse call/mail	Phone/portal access

Adapted from Malik S, Miller S. Redesigning the Patient Experience. Presentation at the Medical Group Management Association Annual Conference. 2007.

tion, improvement in the malpractice system, and efficiency through system redesign.

**Beyond the Fight over Dollars**

There is also a fight between payers and providers. This point is illustrated by Johns Hopkins Healthcare’s suit against regional Blue plan CareFirst of Maryland for \$2 million, claiming that it owes that sum for claims made since October 2004. Johns Hopkins says that CareFirst, the region’s largest health plan, denied or underpaid nearly 15,000 claims. It also claims that CareFirst cut some already negotiated Medicare reimbursement rates without disclosing those changes, used outdated fee schedules, and made mathematical errors.

**Medicare Fund Warning**

This doesn’t just sound scary; it IS scary if you consider

that the portion of Medicare costs financed by general tax revenues is projected to exceed 45% in 2014. To control costs, Medicare Acting Administrator Kerry Weems suggests a 2-pronged approach. “We need to transform the program from being a passive bill payer to an active purchaser of health care by giving quality and cost information to providers and beneficiaries to choose the most effective and efficient care,” said Weems. This statement points to a movement to pay-for-performance and plans to push higher out-of-pocket expenditures to Medicare beneficiaries. Medicare hopes that beneficiaries will choose the most efficient treatments.

Medicare’s movement toward pay-for-performance starts on the physician side with the Physician Quality Reporting Initiative (PQRI). The program that started last year has already undergone some changes. CMS announced on April 17 the addition of new data reporting options for the PQRI. Data can now be submitted via medical registries such as those available through EHRs or through tradition claims submissions.

Participation rates in the first round of PQRI were disappointing, to say the least, with only 15% of physicians reporting and of those, only about half reported successfully. This means that only 8% of all providers eligible were able to report this basic data successfully (Figure 1).<sup>1</sup> Clearly, if pay-for-performance is to be successful, the majority of physicians will need to participate.

Getting physician participation is more difficult than one would expect. Look at the move toward e-prescribing. In April, CMS released the final rule on e-prescribing standards. These standards focused on formulary and benefits, medication history, fill status notification, and provider identifiers. The benefits from a move to e-prescribing would be significant. A study of the Henry Ford Medical Group found that of 500,000 e-prescriptions, 80,000 were canceled or changed due to drug interaction alerts. Despite the obvious benefit of improved medication management resulting from e-prescribing, the sole physician representative on the American Health Information Community advisory group spoke out against mandatory e-prescribing, saying that it was too early for such action.

**The Answer**

There is, of course, no easy answer for increasing efficiency in our complex and fragmented healthcare system. Getting physicians to change will require ensuring that reimbursement is at an appropriate level and that the process works with existing practice methods or requires little change. Technology will play a part in gaining efficiency. As detailed in Table 2, system redesign depends in large part on technology.

Systems such as the American System for Advancing



Senior Healthcare (ASASH; see page 30 in this issue) incorporate technology to deliver education and tools for improving healthcare efficiency, thus reducing waste from our current system. ASASH ([www.asash.net](http://www.asash.net)) was recently launched to focus on empowering seniors to live healthier, more fulfilling lives by providing them and their providers with credible health information and services across a variety of formats. Backed by senior health experts from a range of backgrounds, ASASH is designed to help the 66 million aged 55+ Americans and their healthcare professionals confidently navigate the complexity of the senior healthcare system.

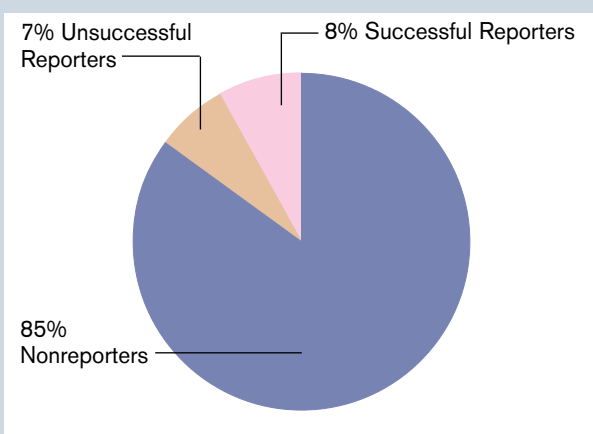
In addition to enhancing senior care delivery through this publication, *Medicare Patient Management*, I am also assisting ASASH. As a reader of *MPM*, I am sure that you will be instrumental in this mission of providing better care to seniors, and I look forward to continuing our dialogues through the pages of *MPM*, our Web site ([www.MedicarePatientManagement.com](http://www.MedicarePatientManagement.com)), and our upcoming comprehensive, 2-day educational event—the Advancing Senior Health Conference ([www.ash-conference.com/](http://www.ash-conference.com/))—where attendees will hear from some of the industry’s top thought leaders; learn about innovative methods of assessment, care, and treatment; and earn continuing education credits.

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**Figure 1. First-round PQRI reporting**



**Reference**

1. Zurnoff R, Coutts L. CMS announces new options for physician quality reporting. *Hematology & Oncology News & Issues*. May 2008; 10.