From the Editor

A Brave New World

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

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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 (cm³), 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.Go4The-Goal.org.

When I started to write this issue's editorial, I began with a working title of "Innovation." Then I realized that much of the innovation revolves around new words, so I changed it to "A New Word." As I wrote my draft, I realized that what I really needed to discuss is the new world that we are entering. A new world that's filled with innovation—new words being thrown into our daily vocabulary and major changes occurring in the Medicare system. These changes to our Medicare system are immediate—like those that are the result of the just-passed *Medicare Improvements for Patients and Providers Act of 2008*. Others are a little farther out, such as the introduction of new diagnostics and treatments. And others moving us into this brave new world will result from us choosing a new president.

The purpose of this editorial as well as the Provider Actions that accompany each of the feature articles in *Medicare Patient Management* is to put you, our readers, ahead of the change curve. This is accomplished by informing you about the latest changes and giving you direction about how to best take advantage of these changes to improve outcomes for your patients and your practice.

A New World: Medicare Reform

The recently passed *Medicare Improvements for Patients and Providers Act of 2008* increases the reimbursement for Medicare providers by moving funds away from Medicare managed care plans. It also is a major move by Medicare into the pay-for-performance arena. While all Medicare providers will receive an increase of 0.5% for 2008 in their Medicare Part B reimbursement and a 1.1% increase for 2009, additional increases are available for those physicians who focus on quality results in their practices and who use innovative systems.

The Physician Quality Reporting Initiative (PQRI), which started July 1, 2007, allows physicians to earn an extra 1.5% on their total Medicare reimbursement. The PQRI bonus increases to 2.0% for 2009 and 2010. The PQRI bonus is a reward for providers who report at least 3 quality measures in 80% (or more) of cases in which the respective measure is reportable. As a result, physicians are well advised to focus on just 3

Table 1. Possible 5.1% Medicare Reimbursement in 2009

Reimbursement Type	Percent Increase		Action Needed
	2008	2009	
Medicare provider reimbursement	0.5%	1.1%	None required
E-prescribing	–	2.0%	Use of qualified e-prescribing system
PQRI	1.5%	2.0%	Positive submission of 80% PQRI data in 3 categories
TOTAL	**2.0%**	**5.1%**	

measures during this first period.

The PQRI measures have been adopted or endorsed by consensus organizations such as the National Quality Forum (NQF) and Ambulatory Care Quality Alliance (AQA). These organizations are leading the charge in quality measures and as such are important to monitor. The NQF is a not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. In September 2004, the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), America's Health Insurance Plans (AHIP), and the Agency for Healthcare Research and Quality (AHRQ), joined together to lead an effort for determining, under the most expedient timeframe, how to most effectively and efficiently improve performance measurement, data aggregation, and reporting in the ambulatory care setting. Originally known as the Ambulatory Care Quality Alliance, the coalition is now known as the AQA alliance because its mission has broadened to incorporate all areas of physician practice.

Congress is also providing incentives for using innovative technology. Long talked about by the Institute of Medicine and others, technology is viewed as an opportunity to increase quality while reducing costs. The *Medicare Improvements for Patients and Providers Act of 2008* Section 132, Incentives for electronic prescribing, provides positive incentives for practitioners who use a qualified e-prescribing system in 2009 through 2013. Penalties apply to practitioners who fail to use a qualified e-prescribing system in 2011 and beyond: payments will be reduced by up to 2%. While these incentives apply to most prescribers, they do not apply to those who only infrequently write prescriptions. Further, the Health and Human Services secretary can establish a hardship exception for providers who are unable to use a qualified e-prescribing system (for example, those in very rural areas).

Because of these incentives, physicians can earn an extra 5.1% in Medicare reimbursement in 2009 (Table 1)—that can be an additional $15,000 for many geriatricians who are able to receive all 3 increased payments. For at least 2 of the 3 increases, there are some additional costs involved in participation. The rewards, however, are not just financial but also include the benefits of improved patient outcomes and practice efficiencies.

The increased resources available to physicians who participate in these initiatives are coming from reductions in the Medicare Advantage plans. These reductions include a direct reduction in reimbursement to plans from a per-member, per-month basis and a decrease in the number of beneficiaries enrolled in Medicare Advantage plans. The Congressional Budget Office estimates a 2.3-million beneficiary reduction in Medicare Advantage plans by those who will be covered under Medicare fee-for-service and stand-alone Medicare prescription drug plans, which cost Medicare less.

A New Word: Theranostics

It's not often you hear a new word that is likely to change the world. A few that have impacted us all come to mind—*Internet, cell phone, iPod*. Another is *theranostics*.

Theranostics (therapy + diagnostics) are molecular diagnostic tests. The results of these tests can predetermine a therapeutic target and the likelihood that a drug will achieve the desired response. Molecularly targeted pharmaceuticals have begun to usher in the promise of personalized medicine, in which genetic tests will determine whether a therapy is prescribed and its costs are reimbursed. Focus has mostly been on oncology treatment because of the high cost and dangers of inappropriate use of these therapies. Many insurers require gene testing as a precondition of payment. This practice is questionable, however, because pharmaceuticals act on proteins, not genes. More ac-

curate ways to match patients and therapies may come from proteomics. *Proteomics* is the study of methods for identifying the proteins that are active in diseased tissues.

The molecular methods that make personalized medicine possible include testing for variations in genes, gene expression, proteins, and metabolites, and new treatments that target molecular mechanisms. These tests could offer substantially more information about a patient's condition including disease susceptibility and progression and likely drug response. Recently, a genetic test to evaluate a patient's suitability for warfarin treatment was introduced.

These innovations, which are leading to individualized or personal medicine, will affect not only how the art of medicine is practiced but also the business of medicine. Molecular diagnostics represents a $5-billion market, growing at an annual rate of 25%.[1]

A New Leader: Presidential Election

While the *Medicare Act of 2008* results in immediate and far-reaching changes in Medicare and theranostics, individualized or personalized medicine is likely to cause change farther down the road. But the upcoming Presidential election will have both an immediate and a far-reaching effect on how we practice senior care.

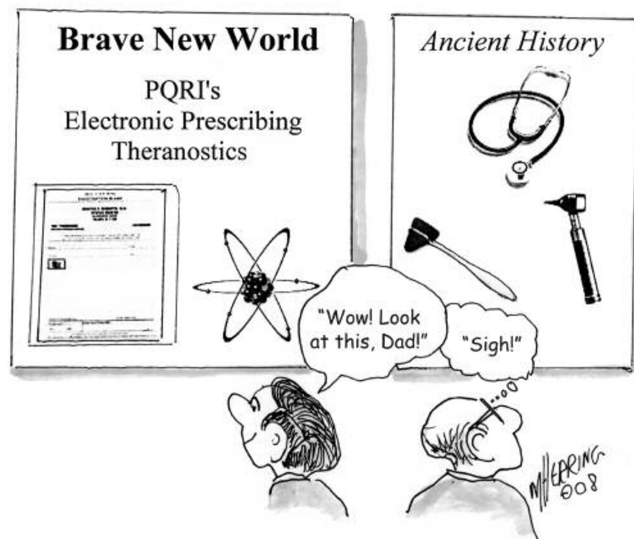
To evaluate the Presidential healthcare platforms, one needs to understand what is being proposed and how these proposals are going to be paid for. In addition, one needs to consider not only the obvious considerations of cost but also the unexpected consequences that may be positive or negative. For example, if a plan places a large burden for healthcare costs on the heads of small businesses, we may lose these businesses that historically have been the foundation of innovation and growth in the American economy.

Specifics of the Presidential healthcare campaigns are found on the Kaiser Network's Web site:

McCain
http://www.kaisernetwork.org/health_cast/presidential hc.cfm?hc=2429

Obama
http://www.kaisernetwork.org/health_cast/health2008 hc.cfm?hc=2164

Listen carefully to these sound bites as you prepare to vote in November and adapt your practice for the changes ahead.



Ready, Set, Go

We are truly entering a brave new world. Decreasing resources cannot keep pace with an increasing patient population with more demands. We must innovate. Incentives will aid physicians, but controls on demand for healthcare services are also critical. One way is to base government contribution on means and define the benefit. The defined benefit would be the minimum benefit package available to all Americans. Beyond that minimum, individuals would be required to purchase supplemental benefits if desired.

In the end, physicians who focus on quality outcomes for their patients through innovation will be rewarded. These rewards will include better patient outcomes and practice efficiencies. We must all understand where we are going, develop a plan for success, and implement the plan. While much is uncertain, rest assured that *Medicare Patient Management* will be here to assist you chart the new territory for success! MPM

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Reference

1. Wyllie MG. Diagnostic potential unmasked. *BJU Int.* 2004;93(4):627-628.