

# From the Editor

## The Future of Health Care

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 (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).

With increased demand in the face of decreasing supply, something in health care has to give. What is the future of health care in the United States? In keeping with the KISS principle, the future can be summed up as "DOCTOR+."

To start, the "+" refers to the need to get back to basics in providing care. We need to focus once again on being complete practitioners, comprehensive holistic providers of care, whether we are nurse practitioners, internists, family practitioners, or geriatricians. The focus must get back to providers delivering preventive, comprehensive care to improve the quality of life of our patients. Congress is already looking at increasing Medicare payments to primary care practitioners, which is likely to come at the expense of specialty practitioners.

This focus on the complete provider or DOCTOR+ is like to get a jump start via a major change in provider reimbursement. This change is being pushed by the likely bundling of Medicare Part A and Part B. There are lots of opportunities for improvements for patients and practices alike, but only for those ready to take advantage of the changes.

Before we get to the rest of the DOCTOR story (Figure 1), let's explain more fully what the bundling of Medicare A and B is likely to mean.

### Figure 1. DOCTOR

- D** iagnostic testing to determine most appropriate treatments
- O** besity and other epidemics
- C** oncierge care
- T** echnology (ERx, EHR)
- O** ncolology treatments and biologics
- R** emote care management

### What Does A + B Equal

Senate Finance Chair Max Baucus (D-MT) recently suggested integrating patient care through a "medical home" concept and bundling Parts A and B physician

payments. Besides the obvious shift of payments to primary care at the expense of specialists, specialists will suffer from this bundling in other ways. Bundling will shift Part B physician reimbursement to the control of the Part A providers, which in most cases are hospitals, nursing homes, or hospice programs. Imagine instead of billing Medicare directly for your services and being reimbursed by Medicare, you would now be paid by the Part A provider. This is likely to result in both decreased reimbursement for and decreased utilization of some providers.

Specifically, instead of a patient's hospital admission being managed by a community physician and a team of consultant specialists, a single hospitalist will not be employed by the hospital to manage the admission. In the same way, nursing homes and hospice organizations will also move to employ providers directly and control their involvement in the management of their residents. This new system will likely save Medicare millions if not billions of dollars, but at whose expense is yet unknown.

This move will favor providers who can improve care rendered to patients in these settings and do so in an effective, efficient manner. It will help if these providers are in short supply as well. You can see from this description that geriatricians and geriatric nurse practitioners will likely be able to demand even greater reimbursement from their current levels while other providers such as podiatrists will likely see their total salary levels decrease because of declining unit

reimbursement and demand for their services.

Bundling of Parts A and B will favor old-fashioned practitioners—those providers who can deliver comprehensive and valued services. Specialists are likely to lose out in this scenario.

## DOCTOR+

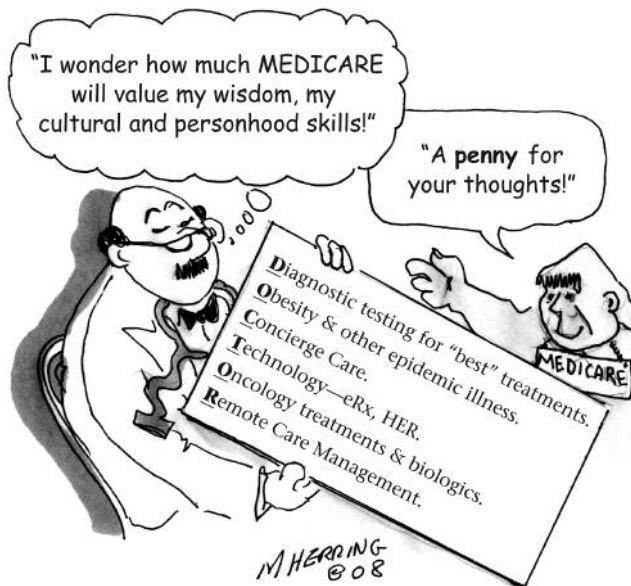
Now to the rest of the DOCTOR story...each of the letters of DOCTOR spells out a future direction for health care. These future trends start with a focus on diagnostic testing—D. This is testing not for a diagnosis but rather to determine which specific therapy is likely to be the most effective.

For example, theranostics (therapy + diagnostics) are molecular diagnostic tests that can help 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 determine whether a therapy is prescribed and paid for. These tests could offer substantially more information about a patient's condition, including disease susceptibility and progression, and likely drug response.

The O is a focus on obesity and other epidemics. Obesity is a growing epidemic in the United States; more and more Medicare beneficiaries entering Medicare are obese. In some cases, this new Medicare beneficiary can be accommodated only by facilities that can redesign to meet their needs. Changes such as reception area sitting that can accommodate obese patients, exam tables that do not require "jumping" up, and even larger gowns that are suited for the obese patient will be required. Practices will need to develop clinical practices to better manage metabolic disorders to deal with the increasing numbers of obese seniors. And it's not just obesity that is reaching epidemic proportions: so too are disorders such as Alzheimer's disease (AD).

Giving seniors what they want, where they want, and when they want will place tremendous opportunities for those delivering concierge care—C.

Of course, increasing the efficiency through the use of technology—T—is essential. Technology includes E-prescribing and electronic health records (EHRs). Congress is providing incentives for using innovative technology. Positive incentives for practitioners who use a qualified E-prescribing system in 2009 through 2013 have recently been signed into law. There are additional incentives—albeit negative ones—for prac-



**Table 1. Incentives for Use of E-prescribing Systems**

Year	Users of E-Rx	Nonusers of E-Rx	Differences Between Users and Nonusers
2009	2%	0%	2%
2010	2%	0%	2%
2011	2%	-2%	4%

tioners who fail to use qualified E-prescribing system in 2011 and beyond by application of up to 2% reductions in payments (Table 1).

The other O is an increased focus on oncology treatments and biologics. The old blockbusters of inexpensive primary care medications used for chronic diseases are being replaced by specialty driven medications that carry price tags of several thousand dollars. Pfizer recently announced that they are abandoning cardiovascular and weight control drugs for oncology drugs. As strides are made in improving oncology and biologic drugs, many fatal diseases are likely to become chronic illnesses.

Last in the DOCTOR acronym is R—that is, the ability to provide remote care management. The push for convenient care and care that is both efficient and effective is likely to result in more remote care being rendered. This care is likely to take place in the home setting through the use of telemedicine, Web casts, and sophisticated monitoring systems, all in an effort to provide care where seniors are rather than forcing them to the hospital or a physician's office.

### Alzheimer's Disease

While there is a lot of overlap between many of the areas of focus for those interested in being successful in our future health care systems, one disease that is important in all of these areas is AD. At present, about 500,000 new cases of probable AD are diagnosed annually, and 5.4 million baby boomers currently are living with this disease. Treatment of patients with AD will benefit from management by a holistic provider who provides concierge-type care through the use of technology and biologics.

### The Future is Now

So the future is now. Geriatric health care providers can see improvements in their practices and patients by focusing on the DOCTOR+ acronym. Be assured

that *Medicare Patient Management* will keep an eye on all of these issues and specifically show you how to proceed through our Provider Action boxes in each feature article. These Provider Actions explain the impact to you, what you need to know, and what you need to do to be successful. The future is on us. Are you ready? **MPM**



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**We welcome your input.**

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