

Ask the Experts

In this and future issues of *MPM*, we ask a panel of experts to comment on a pressing issue of the day. Let us know if you have suggestions regarding experts you would like to hear from or questions you would like to see addressed.

What is making you mad as hell and how is it affecting your practice and patients?



Marvin E. Herring, MD
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Our editors have given us a forum to identify those Medicare-related “pet peeves” that impact negatively on Medicare-related delivery of effective health care, and, short of a temper tantrum, to “let off steam.” While this may have some therapeutic value in venting aggravation, anger, impotence, and reluctant acceptance of a flawed, mismanaged health care reimbursement system, the exercise doesn’t address any how-to to make really meaningful, significant changes. In an ongoing manner, *MPM* articles and Dr. Stefanacci’s editorials continue to identify, highlight, and offer potential remedies to many of the barriers, but until the one glaringly destructive abomination is addressed and attended to, there will be little comfort and less relief from venting frustrations in words.

That one heartbreaking flaw is the unacceptable underreimbursement for thinking! No reward for application of cognitive skills to make the right diagnosis. No reimbursement for discovering the physical/sexual abuse, the hidden alco-

holism, the functional illiteracy that doesn’t allow even the reading of a prescription label, the telling of bad news (sorry, this takes more than can fit into a 15-minute session.) No acknowledgement of its worth, its value and, ultimately, its necessity, if one is expected (and even mandated) to manage pain, suffering, chronic illness, and cultural and community health issues.

Here’s a quote from a psychiatrist friend of mine on paying bills in today’s world—“No problem! I love it. Use the medicines, and a lot less talk!”

Admission of an elderly woman for dizziness—a 2-day hospital stay, treated for urinary tract infection and discharged. No one stood her up, did a neurologic exam, or diagnosed the cerebellar transient ischemic attack.

Want to make me happy? Don’t just give me an opportunity to complain. Pay me what I’m worth for taking an effective history and physical and providing a diagnosis, and let me use a narrative note, and while you’re at it, Managed Care folks, pay me for the minor surgeries and the joint and trigger site injections as an alternative to referral. (Sorry about that one; that’s another tantrum!)

Richard Bringewatt
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While “Mad as hell and not going to take it anymore” is generally not part of my lexicon, there is an issue that troubles me greatly, particularly in the midst of all the discussions about health care reform. That is the relatively limited attention that is being given to improving care for frail, disabled, chronically ill persons, as a matter of priority.

It is absolutely vital that we do everything we can to provide quality, affordable health care for all Americans. It is critical that we do everything we can to advance prevention and health information technology (HIT) programs. It is inexcusable for a country of our wealth and power to be ranked among the least healthy people among the more advanced countries of the world in addition to having millions of people uninsured. But, it is also inexcusable to be in the midst of a once-in-a-

lifetime debate about health care reform and have so little focus on the unique care needs of the already frail, sick, and disabled.

Virtually every health care professional in America knows that current methods of caring for persons with serious chronic conditions are fundamentally flawed. We also know that two-thirds of Medicare spending is on persons with five or more chronic conditions. Over 70% of Medicaid spending is for elderly and disabled persons. Each year we spend over \$250 on care of persons who are dually eligible for Medicare and Medicaid. While some of the discussion about medical homes, bundling, and accountable health care organizations are important for advancing care for high-risk populations, they will not fully address the inadequacies and fundamental disconnects in caring for persons with multiple, serious, and ongoing care needs, as they evolve over time and across care settings.

We can and must do everything we can to reduce the incidence rates of chronic illness; but even the best prevention scenario will not eliminate the fact that the majority of health care dollars are and will continue to be spent on care of frail, disabled, chronically ill persons. We, as a nation, say that we value primary care, particularly those who care for our most vulnerable populations, yet we continue to underpay primary care physicians who specialize in geriatrics, with significant disparities in payment for physicians with a more narrowly defined area of expertise. We say, as a nation, that care of persons with serious and persistent medical conditions is important, yet we maintain a risk adjustment methodology that continues to overpay for the relatively healthy and underpays for high-risk beneficiaries, relative to fee-for-service (FFS). We say that FFS is in part responsible for the fragmentation of care for high-risk groups, yet focus primarily on refining FFS, rather than improving managed care, as we advance our health care reform agenda.

We can and must empower primary care and improve communication among related hospitals and physicians, across the spectrum of financing options; but unless we find a cure for death ... something I don't expect anytime soon ... most of us are going to spend more years of life with more medical problems and more frailty and confusion than any of us would like to believe. State and federal governments must control the escalation of Medicare and Medicaid costs, but significant cost and quality improvement is not likely unless we pay more attention to the pervasive disconnects in

the ongoing financing, administration, and delivery of care of persons dually eligible for Medicare and Medicaid. Each piece of care, each federal and state program, each intervention is important. But, the solution for improving the *total* quality and cost performance of our care system is more related to the systemic nature of chronic illness than it is to improving any one care or program component.

It is very exciting and energizing to see the kind of attention that is being given to advancing health care reform, particularly given the severity and complexity of our current downturn in the economy. However, until and unless we give more focus to the systemic nature of care persons with serious and disabling chronic conditions need as they evolve over time and across care settings, and take steps to fundamentally transform how we care for our nation's most vulnerable, high-cost persons, not only are we going to miss a golden opportunity to marshal the engines of reform to do something about this important, needy segment of our population, but we will fail to reduce costs or fundamentally improve the quality of our health care system as a whole. The needs of the frail, sick, and disabled are too great. They are too important to ignore. The time to act is now!



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The major issue for health care providers, ie, hospitals and physicians, is the inability of our industry representatives to lobby for acceptable levels of payment. For hospitals, Medicare reimbursement has not kept up with cost inflation, resulting in 30% or more of the hospitals operating at a deficit without any hope of accessing capital. Physicians have been given a 1% increase in their fee schedule while their practice expenses have increase by 5% per year. In response to this, many physicians have initiated imaging services in their office to stabilize their incomes. Now in-office imaging is in the cross hairs of reimbursement reductions. The unintended consequences of most political solutions to the escalation in health care costs have been, are, and will be devastating to health care providers.

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