From the Editor

It's a Tough Time for Overachievers

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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^3), 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.

Dr. Stefanacci's proudest accomplishment is as founder and member of the board of directors of www.Go4TheGoal.org.

Mission Statement
Medicare Patient Management (MPM) is the first and only journal focused on enhancing care for seniors as Medicare reforms force a shift from an acute care, volume-based paper system to an integrated digital system of enhanced preventive care. Quality-of-care issues become paramount for physicians, managed care insurers, and nearly 42 million Medicare beneficiaries. *MPM* helps to enhance care for seniors by offering:

- Tools to help practitioners implement evidence-based medicine
- A discussion of evidence-based prescribing models that examines medication costs and benefits
- Insight on the integration of innovative information systems in clinical practice
- Help for providers to improve outcomes for their patients and their practices

It used to be easy—study your #%@ off to get to and through medical school and residency to open a practice just to work your #%@ off still so that you could take care of your patients and family. Today the latter part has become very difficult, if not impossible. Because of major shifts in the Medicare and health care landscape, producing good outcomes for patients and families has become very difficult. Why has it become so very difficult and, more important, what can we do to again get to a place where we feel comfortable delivering care?

Bonuses With Strings

At first blush, one might be excited about the increased attention to health care, especially primary care, by the Obama administration. Under the American Reinvestment and Recovery Act there is almost $20 billion for providers who use certified health care information technology (HIT). Plus, there's additional funding for primary care providers. But as with most things, the devil is in the details.

The HIT incentives are scheduled to take effect starting October 1, 2011. Payments are provided in graduated, descending amounts for federal fiscal years 2011 and 2015. As with e-prescribing, there are penalties for providers who do not use HIT after 2015.

According to the Healthcare Information and Management Systems Society's (HIMSS)[1] interpretation of the law, physicians can earn from $44,000 to more than $60,000 in extra payments over the 5-year period. The maximum payment for qualifying physicians under the stimulus package is $18,000 for the first year, $12,000 for the second year, $8,000 for the third year, $4,000 for the fourth year, and $2,000 for the fifth year. For those failing to use certified qualifying HIT by 2014, Medicare payments will be reduced to 99% in 2015, 98% in 2016, and 97% thereafter.

To qualify for bonuses, providers must have certified electronic health record (EHR) technology capable of providing clinical decision support to physician order entry and capturing query information relevant to health care quality. The system must also be able to exchange and integrate electronic health information with other sources.

The reason for this significant investment in HIT includes:

- Fewer adverse drug events, medical errors, and redundant tests and procedures because EHRs can ensure physicians have access to an accurate and complete health history
- Faster diagnoses and treatment of serious illnesses with comprehensive information available at the touch of a screen
- Timely provision of preventative care and services, such as health screenings, which can help reduce health care costs
- Better communication between patients and physicians, giving patients enhanced access to timely information
- Shorter wait times for patients and lower operating costs for physicians through improved office efficiency

While there are obvious benefits for implementation of HIT, there are also significant costs. The most significant of these costs is for the implementation of the HIT system within a practice. The research by Robert Miller, PhD, and colleagues at the University of California, San Francisco, supported by the Commonwealth Fund, found that for small group practices with EHRs, initial costs average $44,000 per physician with ongoing costs averaging $8,400 per physician per year.[2]

It appears that at best each physician will break even while most will actually lose money over the long haul from these HIT investments.

The study, titled "The Value of Electronic Health Records in Solo or Small Group Practices," published in *Health Affairs,* September/October 2005 by Miller and his team, found that initial costs ranged from $37,056 to $63,600 per physician. So between these two studies, HIT investments were approximately $50,000 per physician. In addition to these initial expenses, there were several thousand dollars per year as well as expenses related to staff training, billing problems, and data loss.[2]

In addition to the HIT investment, there is also money being invested in primary care. Actually over half a billion dollars is set to be spent on training primary care providers, a portion of which would be used to cover the medical school expenses of students who agree to practice in underserved regions through the National Health Services Corps.

So while there are funds available for new primary care physicians, especially, as far as the HIT investment goes, it appears that at best each physician will break even while most will actually lose money over the long haul from these HIT investments.

Unfunded or Underfunded Mandates

There are several unfunded or underfunded mandates, including:

- e-Prescribing
- Pay-for-performance
- EHRs
- Move to International Classification of Diseases, 10th edition (ICD-10)

Both e-prescribing and EHRs have payment bonuses attached, but these payments only come after a significant investment in hardware, software, and staff training. In addition, there is often lost productivity and increased errors that add to the financial burden of meeting the requirements to collect these bonuses.

With regard to pay-for-performance, the cost of going after these same bonus payments has certainly not been enough to outweigh the burdens to be successful. As a result, most physicians remain firmly planted on the sideline unable or unwilling to participate. Data show that most physician remain nonreporters, and of those who do make the effort to report, only about half are successful. And of those who are successful, the payment has only been about $700, which appears much less than the cost of being successful.

Yet another major unfunded mandate on the horizon that has been out there for some time is the ICD-10 system. ICD-9 is a set of codes for recording the causes of mortality and morbidity. In the late 1970s, the United States developed a clinical modification of this code set and mandated its use for all diagnoses. ICD-10 has been around since the early 1990s. But the costs of making the change from ICD-9 to ICD-10 include costs of training, productivity losses, and system change requirements.

The RAND Corporation published "The Costs and Benefits of Moving to the ICD-10 Code Sets" in 1994.[3] At that time, RAND estimated that the cost of

conversion would run to over $1 billion in one-time costs plus somewhere between $5 million and $40 million a year in lost productivity. This translates into a cost of almost $90,000 for the average three-physician practice.

But don't panic on this one quite yet, for although the ICD-10 has been planned for some time with the most recent date of implementation set for 2011, that mandate has been delayed now until October 1, 2013. But the bottom line remains the same—that is, be sure to have all of these mandates on your radar and begin preparation well ahead to minimize the impact.

Tough Times for Overachievers

This is a tough time for everyone—the three major areas of economic security have all seen a dramatic decline—home values, job security, and retirement accounts. It is these three areas that make up most individuals' perception of their financial health and well-being.

What is less clear is the effect of the government's latest moves to improve the situation. The *New York Times* describes the federal proposals as "a pronounced move to redistribute wealth and reimpose a substantially larger share of the tax burden on the most affluent taxpayers."[4] While this may seem like an easy and painless fix for paying for all the federal promises and bailouts, the *Wall Street Journal* editorializes, "Even the most basic inspection of the IRS income tax statistics shows that raising taxes on the salaries, dividends, and capital gains of those making more than $250,000 can't possibly raise enough revenue to fund Mr. Obama's new spending ambitions."[5] So where does this leave the overachieving health care provider who is trying to take care of his patients and family?

Physicians are dazed and confused, wondering how they can possibly continue or what changes need to be made to remain successful. An increasing number of physicians are considering turning their practices into a concierge or boutique practice. But before cashing out or cashing in by moving to a concierge/boutique practice, physicians may want to think again. Some state insurance commissioners have recently considered classifying retainer-based practices as a type of insurance.

The bottom line is that to keep our patients and ourselves healthy and happy, we must become politically active since our patient care level is increasingly being dictated at the government level. To continue to be successful in these changing times, providers must not only stay abreast of the changes but work to make sure that these changes being dictated by Washington are truly in the best interest of our patients. Today much of what is happening calls this into question. MPM

So much government, so little common sense

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