Medicare Looking to Help Senior Smokers Kick the Habit

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

Medicare is investigating ways to help its beneficiaries quit smoking.

The Centers for Medicare and Medicaid Services proposed to extend smoking cessation coverage to beneficiaries who smoke and have been diagnosed with a smoking-related disease—or who are taking certain drugs whose metabolism is affected by tobacco use.

The hope is that Medicare's decision to pay for smoking cessation counseling "will encourage and help seniors quit smoking once and for all," Ronald Davis, M.D., trustee to the American Medical Association, said in a statement.

Of the 440,000 Americans who die annually from smoking-related disease, 300,000 are aged 65 and older, according to the Centers for Disease Control and Prevention. More than 9% of those aged 65 years and older smoke cigarettes.

The CDC in 2002 estimated that 57% of smokers aged 65 and older reported a desire to quit smoking.

The proposed coverage decision specifically applies to patients whose illness is caused or complicated by smoking, such as heart disease, cerebrovascular disease, lung disease, weak bones, or blood clots—diseases that account for the bulk of Medicare spending, according to the CMS.

Beneficiaries are also eligible for the counseling if they take medications whose effectiveness is complicated by smoking, including insulins, and medicines for high blood pressure, seizures, blood clots, or depression.

Minimal counseling is already covered at each evaluation and management visit for beneficiaries. Beyond that, Medicare is proposing to cover two cessation attempts per year. "Each attempt may include a maximum of four intermediate or intensive sessions, with the total annual benefit covering up to eight sessions in a 12-month period," the proposal stated.

The CMS estimates the program will cost $11 million annually, a number it expects will be offset by fewer hospitalizations and health problems related to smoking.

In addition to heart disease, emphysema, and stroke, seniors who smoke cigarettes are also more likely to develop problems associated with older age, such as hip fractures, eye cataracts, and facial skin wrinkles, Dr. Davis said.

Seniors who try to quit smoking are 50% more likely to succeed than other age groups, and those who quit can reduce their risk of death from heart disease to that of nonsmokers within several years of quitting, he added.

In a statement, CMS Administrator Mark McClellan, M.D., encouraged smokers on Medicare who were starting to experience heart or lung problems, or high blood pressure "to take advantage of this new help—and more is coming." The agency noted that Medicare's upcoming prescription drug benefit will cover smoking cessation treatments that are prescribed by a physician.

The American Lung Association supported the effort but had concerns that comparable benefits weren't available to younger patients.

The group "applauds anything that will help anyone stop smoking," spokeswoman Diane Maple told this newspaper. However, a recent study showed that only 10% of employer-sponsored health plans cover smoking cessation programs that combine medications with counseling, she said. "There are a lot of people out there who are not eligible for Medicare and won't get these types of benefits from their personal health plans."

The association hopes that private plans will take a cue from Medicare and develop similar programs in the future, she said. ■

Medicaid Managed Care's Financial Benefits Elusive

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — Medicaid managed care doesn't appear to be living up to its reputation for cost savings, at least not in South Carolina, Walter Jones, Ph.D., said at the annual meeting of the American Public Health Association.

Dr. Jones and his colleagues looked at 2 years' worth of data on 56,000 Medicaid HMO patients and 21,000 patients in the state's Physician Enhanced Payment (PEP) program, a Medicaid plan in which primary care physicians are paid an extra fee to "case manage" the patient's health care needs. Both groups were matched with comparable fee-for-service patients.

Provider participation has been unstable. An HMO comes to the state, thinks it can make money, finds it can't, and leaves, and the merry-go-round goes on and on.

South Carolina "is not a heavily managed care state. We have very little HMO penetration," said Dr. Jones, professor of health administration and policy at the Medical University of South Carolina, Charleston. "Unlike a lot of Medicaid programs, South Carolina does not have mandatory HMO assignment; physicians wouldn't stand for it. As a consequence … there's been a lot of unstable provider participation. An HMO comes to the state, thinks it can make money, finds it can't, and leaves, and the merry-go-round goes on and on."

But the PEP program is a much different form of managed care, he said. The primary care physician provides a "medical home" for the patient for a flat fee but is not financially penalized for putting a patient into specialty care. Also, PEP physicians are expected to be "very available," reducing the need for costly emergency room care, Dr. Jones said.

The researchers looked at several aspects of medical care utilization, including primary and specialty care, inpatient hospitalizations, and emergency room visits. They also included a separate category for "total utilization," which included pharmacy use and other services as well as physician and hospital care.

They found that on the surface, both HMOs and PEP reduced utilization. Patients in HMOs had five fewer health care visits for a 2-year period, compared with fee-for-service patients, and PEP patients had two fewer visits. But there was a problem among the HMO patients: the reduced visits included those for primary care as well as for specialty care.

"That's not what managed care is supposed to be doing," Dr. Jones said. "With the PEP project, utilization goes down a little less, but there's no difference in primary care utilization. It appears … that PEP is doing exactly what it should be doing—controlling utilization but not on the primary care level."

Another problem with the HMOs, he continued, is that they "cream skim." "When you control for the HMOs' patient selection, their utilization differences disappear with respect to fee for service. The way they're reducing costs is by keeping the less desirable clients out." This is often accomplished by not setting up enrollment offices in areas of the state where sicker patients are more likely to live, he told this newspaper.

Although patients in both PEP and the Medicaid HMOs decreased their utilization of certain kinds of care, total health care utilization actually appeared to go up in both groups, Dr. Jones noted.

"If you're the state and you're trying to save money, you might be kind of dismayed. On the other hand, if you're an advocate for patients, it doesn't appear that applying managed care reduces the number of services," he said.

Overall, the study "raises questions about the utility of Medicaid managed care," he said. "The assumption always has been that HMOs or other managed care plans could do for Medicaid clients what it's done for private sector healthy employees; we haven't found that to be true. The bottom line is, it's still kind of 'faith-based' health care." ■