POLICY & PRACTICE

Bill Halts 4.4% Cut

Congress' long-awaited passage of the budget reconciliation package (also called the Deficit Reduction Act) put a freeze on a 4.4% Medicare pay cut that physicians experienced in the month of January. The congressional action stopped any further reductions but did not increase Medicare physician pay for 2006. The Centers for Medicare and Medicaid Services will reimburse physicians retroactively for the January reductions, and has instructed its contractors to automatically reprocess claims. But work on this issue is far from over, Dr. J. Edward Hill, president of the American Medical Association, said in a statement. "With 6 years of cuts still scheduled to come as practice costs continue to rise—we fear more physicians will make difficult practice decisions about treating Medicare patients. … We must build on the momentum and awareness raised in 2005 to make 2006 the year Congress permanently repeals the broken Medicare physician payment formula." President Bush's fiscal year 2007 budget request to Congress briefly mentioned the impending cuts, but it also expounded on CMS's efforts to expand pay-for-performance initiatives to "achieve better outcomes at a lower overall cost."

And on to the 2007 Budget

The President's 2007 budget request for the Department of Health and Human Services—$698 billion—is a $58 billion increase from 2006, but contains cost-containment measures that would whittle down or eliminate certain programs. Medicare initiatives to "encourage efficient and appropriate payment for services; foster competition; and promote beneficiary involvement in their health care decisions" would save nearly $36 billion from 2007 to 2011, according to an HHS statement. But Part A hospital payments would incur $22 billion of these cuts— "the wrong policy at the wrong time," as hospitals have been losing money caring for Medicare beneficiaries since 2003, said Chip Kahn, president of the Federation of American Hospitals. Aiming to meet the president's goal of cutting the federal deficit in half by 2009, the budget request proposes other targeted reductions or elimination of certain programs whose performance ratings were low or whose purposes are being covered by other HHS programs. These cuts include $133 million to rural health programs run by the Health Research and Services Administration, and elimination of the $630 million Community Services Block Grant program. Several organizations decried the proposed cuts to National Institutes of Health research programs. The National Institute of Diabetes and Digestive and Kidney Diseases would be funded at $11 million less than in 2006, according to the American Diabetes Association. Also, the Centers for Disease Control and Prevention would receive only $819 million for chronic disease programs, a $20 million reduction from last year, the ADA reported. Some programs took special priority in the request—the president, for example, asked for $4.4 billion for bioterrorism-related spending in 2007, a $178 million increase over 2006. To achieve the president's goal for most Americans to have secure personal electronic health records by 2014, $169 million was requested for 2007 ($59 million more than in 2006) for health information technology. The Food and Drug Administration's 2007 budget request totaled $1.95 billion, a 3.8% increase over 2006. Much of these additional FDA funds would be used for pandemic prevention, promotion of molecular medicine, and protection of the food supply from bioterrorism.

Not So Sure on Quarantines

Americans are in favor of quarantines as a protection against infectious diseases—but when it comes to the enforcement and monitoring of quarantines, they're not as receptive as people in other countries, according to a Web-exclusive Health Affairs study titled "Attitudes toward the Use of Quarantine in a Public Health Emergency in Four Countries." Residents of the United States, Hong Kong, Singapore, and Taiwan were polled for the study. Certain enforcement measures received wide support in the Asian nations, but only 53% of Americans said they would favor a requirement for everyone to wear masks in public in the event of disease outbreak. Only 44% supported screening for illness by taking people's temperature before they entered public places. Americans were also less supportive of quarantine compliance measures such as guards, electronic ankle bracelets, and periodic video surveillance, compared with residents of the Asian nations. The use of arrest to maintain quarantine had limited support in all of the countries. Only 42% of the U.S. respondents supported a compulsory quarantine where noncompliant individuals could be arrested, the study indicated.

CVD Awareness Rises

More women are aware of cardiovascular disease, and that knowledge is causing them to take positive preventive health steps for themselves and family members, according to a recent study published in the journal Circulation. A survey of more than 1,000 women aged 25 and older found that awareness has nearly doubled since 1997. Among the women who completed the full survey in July 2005, 55% said that heart disease/heart attack is the leading cause of death. This is up from 30% in 1997. In addition, about 54% of women who reported seeing a health care professional on a regular basis said they had discussed their risk of heart disease within the past 6 months. The top reason women cited for not speaking to a physician or other health care professional about heart disease in the last year was that the provider did not bring it up.

—Jennifer Lubell

'Part E' Pitch Is Made For Long-Term Care

BY JENNIFER LUBELL
Associate Editor, Practice Trends

WASHINGTON — Medicare should create a new benefit to more adequately address long-term care, delegates to the 2005 White House Conference on Aging recommended.

In one of the many implementation plans to improve the health care of aging patients, the delegates to the conference called for the implementation of a "Part E" to the Medicare program, a comprehensive, lifetime, long-term care benefit that would be available to Americans of all ages.

Because Medicare is going bankrupt, and most monies used to pay for long-term care come from Medicaid, "we have to do something to help offset the financial costs associated with a projected increase in these services in the next 10-15 years," Dr. William Woolery, a delegate from Georgia, said in an interview.

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The current Congress isn't likely to be receptive to creating a Part E benefit to cover long-term care, Dr. Moira Fordyce said.

Most nursing home beds are long-term care—paid for either by private funding sources or by Medicaid. A few of the beds, however, qualify as "skilled" facilities and are paid for by Medicare Part A.

"In general, nationwide, there are nonskilled or long-term stay beds for long-stay patients and skilled beds for short-term skilled admissions for things like post–hip fracture recovery or rehabilitation for stroke," explained Dr. Charles Cefalu, a geriatrician from Louisiana and a member of the American Medical Directors Association, who attended the conference.

Patients have only a small number of options once their coverage for skilled care has been terminated, Dr. Moira Fordyce, a geriatrician and an adjunct clinical professor at Stanford (Calif.) University, said in an interview.

Under the current system, a short-term hospital stay is required before skilled nursing home, home care, or rehabilitation will be paid for by Medicare. Then the Medicare payment is limited to a period of 100 days per condition per lifetime. Such a payment level is "not enough when chronic illnesses over many years are the norm," she said. Unless skilled care is involved, and the patient is improving, the payment stops.

Personal care is only covered while skilled care is being given. "This means, for example, that someone at home who is coping with chronic illnesses who just needs help in the morning to get out of bed, wash, and have breakfast, then help in getting to bed in the evening would have to pay for this, if he or she has no family to help," Dr. Fordyce said.

For these reasons, a Part E should also cover home care, in addition to nursing home care; "otherwise it will not be of great value," she said.

There are many people in nursing homes that could be at home if this type of help were available, she continued. "Home is preferable, and less costly to the patient and society than nursing home care—now costing anything from $40,000 to $60,000 or more each year."

Creating a Part E to accommodate these types of long-term care patients would require congressional action. Peter Ashkenaz, a spokesman for the Centers for Medicare and Medicaid Services wouldn't comment specifically on the proposal, only that CMS "would be interested in seeing the final report [from the White House Conference on Aging] based on the final resolutions, and await any actions" on those resolutions.

It's unlikely that the current Congress will be receptive, "but we must start somewhere and keep after them until something is done," Dr. Fordyce said. "When there are enough vociferous voters, Congress will have to listen."

Dr. Cefalu wasn't as convinced. "It seems far fetched that Medicare would opt to fund nonskilled nursing home beds that are currently paid for by private or Medicaid services," considering that the program is overwhelmed with the drug benefit—and that skilled nursing home units and skilled units in acute care hospitals are already trying to cap or rein in skilled nursing home costs with prospective payments, he said.

"It's a pipe dream. Congress is not going to approve it," he said.

To get resources for a Part E, "we would have to review the alignment of government programs that deliver services to older Americans, look at all programs out there, see where there is duplication, and cut out redundancy," Dr. Judith Black, a geriatrician and delegate from Pittsburgh said in an interview.

Until that's accomplished, "I don't see how we'll have funding available," Dr. Black said. ■