Medicare 'Part E' Pitch Made for Long-Term Care

A main concern is that patients have few options after coverage for skilled care has been terminated.

BY JENNIFER LUBELL
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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 called for the implementation of a "Part E" to the Medicare program, a comprehensive, lifetime, long-term care benefit available to Americans of all ages.

Because Medicare is going bankrupt, and most of long-term care monies 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.

Most nursing home beds are long-term care—paid for by either private funding or Medicaid. A few, 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 few options once coverage for skilled care stops, 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 payment is limited to 100 days per condition per lifetime, "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," she said. ■

Elderly Lose as Rules Choke Health IT Progress

BY JENNIFER LUBELL
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WASHINGTON — The United States has underinvested in health information technologies that could help improve the lives of elderly people, said Craig Barrett, chairman of the board of the Intel Corporation, at the 2005 White House Conference on Aging.

"Many other countries are ahead of us," said Mr. Barrett. For example, in Korea, user-friendly devices such as cell phones that double as glucose monitors are being tested.

Research and development funding is needed to fast-track approval for this type of technology and to bring it to the market, Mr. Barrett said. Trials of this kind are taking place in Europe, but in the United States, licensing, regulatory issues, issues of reimbursement, and liability concerns are holding things up, he said. Physicians, for example, don't use e-mail to communicate with patients because they are not reimbursed for giving advice over the Internet.

If the United States were to coordinate companies' efforts to tap research and development funding for such technologies, elderly patients would be able to live better quality lives in their homes, rather than in hospitals and clinics, he argued.

Those efforts would also help lower the medical costs of caring for elderly patients, who make up 15% of all patients, but who account for 85% of medical costs, Mr. Barrett said. "If we can figure out a way to lower those costs to help that small population of people, we'd be much farther ahead."

A variety of devices capable of monitoring information about diseases could be made available to the three major participants in health care: the individual patient, the caretakers, and family doctors, he said.

'You could turn the health care system around so that all sorts of technology could be used at home to ward off having to go to the hospital.'

"You could turn the health care system around so that all sorts of technology could be used at home to ward off having to go to the hospital," he said. For example, one could put a pedometer on a patient who has a wireless connection to a PC to encourage him or her to walk 4 miles a day. This would outline the goals and allow the patient to monitor performance and achieve the goals.

By placing monitoring devices in the home, "you could sense if individuals are walking around, opening refrigerators, if they're taking their medication." The monitoring could be done remotely so that caregivers and family could regularly check on their elderly patients or parents.

Monitoring technology could also help track the condition of a patient with a chronic disease, to see if a patient is worsening. Variables such as mobility, sleep quality, heartbeat, and breathing regularity can be readily tracked using sensors that are available today, he said.

Finally, such technology could be used to improve lifestyles of older patients, said Mr. Barrett. "People who have memory problems often don't want to answer the phone because they're afraid they're not going to know who's on the other end. They don't want to answer the door because they're afraid they might not recognize who's at the door." One solution would be to give such patients a simple, enhanced call monitoring system that shows a picture of the caller or visitor, explains their relationship, and informs the patient when they last spoke.

To improve access to and the quality of care for elderly patients, the White House Conference on Aging delegates approved several implementation plans to advance health information technology, such as:

► Updating Medicare to emphasize the establishment of cost-effective linkages to home and community-based options through the Aging Network, to promote chronic disease management, and to increase health promotion and disease prevention measures.

► Establishing a new title under the Older Americans Act to create aging and disability resource centers as single points of entry in each region across the country to coordinate health and aging programs and ensure access to diverse populations.

► Including provisions in the Older Americans Act to foster the development of a virtual electronic database that providers can share.

► Amending the Health Insurance Portability and Accountability Act and other "restrictive" regulations to allow for communication between health providers and the Aging Network. ■

INDEX OF ADVERTISERS