Wider-Ranging Plans Urged for Nursing Homes

Evacuation arrangements for major disasters need to involve local police and emergency units.

BY ALICIA AULT
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After reviewing nursing homes’ emergency plans and outcomes of evacuations and sheltering for the last two hurricane seasons, the Health and Human Services Department’s Office of Inspector General is suggesting that the Centers for Medicare and Medicaid Services strengthen federal emergency management standards for long-term care facilities. Of the 16,125 nursing homes inspected nationwide in 2004 and 2005, 94% met federal standards for emergency plans, and 80% met those standards for emergency training, the OIG said.

The rates were similar for the 2,526 facilities in the Gulf states of Alabama, Florida, Louisiana, Mississippi, and Texas, according to the OIG’s report. But it found in many cases that nursing home administrators and staff did not follow their own plans, or lacked transport or other resources to effect those plans in a crisis.

The office reviewed state survey data for emergency preparedness and interviewed nursing home staff and administrators and local authorities in nine counties across the five affected states. The OIG found no evidence suggesting any problems with 20 nursing homes caught in hurricanes Ivan in September 2004, Katrina in August 2005, Rita in September 2005, and Wilma in October 2005, and compared those plans with provisions required by state law.

All 20 homes ran into challenges, whether they evacuated or not. All administrators said evacuation was not necessary, the best course of action as it could cause physical and mental stress. They also cited transportation contracts that weren’t honored; complicated medication needs, and host facilities that were not available or prepared to receive evacuees.

Homes where patients were sheltered in place did not have as many problems overall as homes that were staffed and supplies issues. At 5 of the 20 homes, administrators said they deviated from the prepared plan because the plan wasn’t up to date or did not address their situation. Six homes did not have instructions on how to evacuate to an alternative site, nine did not have any guidance on how to decide whether to evacuate or shelter in place, and 11 did not have any instructions on how to return to the homes after an evacuation.

Still, Dr. John Morley, director of the division of geriatric medicine for St. Louis University, said there is a need for a traditional plan, saying this is an issue that “goes beyond a local plan and expecting nursing homes to do everything them- selves.” He said “local police, emergency units, and everyone needs to be involved.”

The reality is that evacuation plans have to go beyond the facility because “if something goes wrong, it will affect” the entire area, Dr. Morley said. A facility may plan to use local buildings in an extended out- age, but if there is a major disaster, “you probably have to move to another coun- try,” he said. Dr. Morley said the issue is not only having a plan and following it but “know- ing when to evacuate,” given the risks of moving such a vulnerable population.

“Nursing homes are not going to do that because many of them did not evacuate. I think that did not evacuate were criticized, and oth- ers that tried to move to Houston had tragic deaths,” Dr. Morley noted. He said emergency planning fails apart in older populations, including those in home care and hospice care, because “no one is very interested. We’re an ageist society—we don’t like old people so we don’t plan for them. Then, we get all the upset when things go wrong.” Dr. Morley also stressed the need for an “electronic database” to track patients as part of disaster preparedness.

The challenge of evacuations was un- derlined. CMS staff are drafting in- dicements against two nursing home owner- ers in New Orleans’ St. Bernard Parish. The Katrina surge flooded the one-story facility to the ceiling in 20 minutes. The owners, Mabel and Salvador Mangano, were charged with negligent homicide in the drowning of 35 residents. However, they have maintained their innocence, saying they were worried that frail residents wouldn’t survive the ordeal of an evacua- tion. The couple also has filed a legal doc- ument asking a judge to name a slew of state, local and federal officials as codefendants in related complaints. The case is not likely to be resolved soon.

On a larger scale, to ensure better prepared- ness, CMS staff are drafting a core set of required elements tailored to specific lo- cal risks, the OIG said, adding that the agency should also encourage greater col- laboration between nursing homes and emergency management authorities.

Medicare Part D Doughnut Hole May Not Be Worth Filling

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Rhetoric aside, it’s not clear whether lifting restrictions on the government’s ability to negotiate pharmaceutical prices for the Part D ben- efit will have any real impact, experts said at a forum on the future of Medicare sponsored by the Association of Health Care Journalists.

In January, the House of Representa- tives passed H.R. 4, which would require the Secretary of Health and Human Ser- vices to negotiate drug prices directly with manufacturers, similar to what is done by the Veterans Affairs system. In the Senate, Sen. Edward M. Kennedy (D-Mass.), who chairs the powerful Health, Education, Labor, and Pension Commit- tee, has placed this legislation near the top of the committee’s agenda.

“I’m a little perplexed at how this issue is going to play out,” said Paul Ginsburg, Ph.D., president of the Center for Studying Health System Change. “In a sense, if you really want the government to ne- gotiate with manufacturers, you might as well repeal, not the benefit, but the whole structure of delivering it.”

The Part D program is based on the concept that the different plans would compete with one another based on price, said Marilyn Moon, Ph.D., vice president and a director of the Center for Health Research at the American Institutes for Research.

“If you hand them a price list, there’s really no reason for them to be there. It’s very difficult to imagine how you would do this,” she said.

Dr. Moon agreed. “This is going to be much more of a morass than people think,” she said. “It’s a mistake on the part of a lot of the Democrats to have been promising that’s what we’re going to do.”

Medicare already sets prices for physi- cian services and many medical proc- edures, but setting prices for prescription drugs is a far more complicated proposi- tion, Dr. Ginsburg said.

“Setting prices for pharmaceuticals, given the fact that the actual production costs of pharmaceuticals are a very small part of the total cost of pharmaceuti- cals—most of it is in R&D for that drug and for the drugs that didn’t make it—that’s a much more challenging job to do well,” he said.

However, Democrats argue that nego- tiating drug prices will help solve other problems with Part D.

Giving the government the ability to ne- gotiate drug prices will lower expenses for seniors and yield savings for Medicare that can be used to fill the gap in cover- age known as the doughnut hole, said a statement from Sen. Kennedy’s office.

But the new Congress could design a workarounds to fill the doughnut hole without adding money to the program, Dr. Moon said. “My concern about the doughnut hole is that who it really hits are the people who are taking maintenance drugs, who are also the main ones who can save costs over time.”

By keeping their health problems in check, she said.

Physicians Encouraged to Sign Up Soon for an NPI

BY MARY ELLEN SCHNEIDER
New York Bureau

The clock is ticking for physicians to sign up for a National Provider Identi- fier, the new 10-digit number that will be used by Medicare, Medicaid, and many private health plans to process claims. The deadline for registering for an NPI number is May 23.

Physicians who are not using an NPI af- ter that date could experience cash flow disruptions, according to the Centers for Medicare and Medicaid Services.

The transition to a single identifier that can be used across health plans is re- quired under the Health Insurance Porta- bility and Accountability Act (HIPAA) of 1996. Most health plans and all health care clearinghouses must begin using NPIs to process physicians’ claims in standard transactions by May 23. Small health plans have another year to become compliant.

“The NPI is the new standard identifying number for all healthcare billing trans- actions, not just for billing Medicare or Medicaid. National standards like the NPI will make electronic data exchanges a vi- able and preferable alternative to paper processing for health care providers and health plans alike,” said Aaron Hase, a CMS spokesman. As of Jan. 29, more than 1.6 million NPIs had been assigned, according to CMS.

Physicians and other health care providers can apply for an NPI online or by using a paper application. In addition, organizations like hospitals or profes- sional associations can submit applica- tions for several physicians in an elec- tronic file.

Officials at CMS are urging physicians who haven’t yet signed up to do so soon. A physician who submits a properly com- pleted electronic application could have his or her NPI in 10 days. However, it can take 120 days to do the remaining work to use it, Mr. Hase said. The preparation includes working on internal billing sys- tems; coordinating with billing services, vendors, and clearinghouses; and testing the new identifier with payers, he said.

So far, the process of obtaining an NPI has been relatively easy, said Brian Whit- man, senior analyst for regulatory and in- surer affairs at the American College of Physicians. The application process itself takes about ten minutes, he said.

But one thing to be aware of is that you may already have an NPI. Because some large employers may have already regis- tered their providers, physicians may be surprised to learn that they already have a number, Mr. Whitman said.

As the May deadline approaches and more and more physicians get registered, the next question is how widely CMS plans to disseminate the NPIs. CMS officials have said they are considering creating some type of directory of NPIs that could be available to physicians and office staff.

Physicians can apply for an NPI online at https://nppes.cms.hhs.gov or call 1-800- 463-3203 to request a paper application.