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 transportation 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 took an in-depth look at plans from 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 necessarily 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 but still had staffing 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 an additional plan, saying this is an issue that "goes beyond a local plan and expecting nursing homes to do everything themselves." 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 outage, but if there is a major disaster, "you probably have to move to another county." Dr. Morley said the issue is not only having a plan and following it but "knowing when to evacuate," given the risks of moving such a vulnerable population.

Indeed, during Katrina, facilities that did not evacuate were criticized, and others that tried to move to Houston had tragic deaths, Dr. Morley noted. He said emergency planning falls 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 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 underscored in the Sept. 21 grand jury indictments against two nursing home owners 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 evacuation. The couple also has filed a legal document asking a judge to name a slew of local, state and federal officials as co-defendants in related complaints. The case is not likely to be resolved soon.

On a larger scale, to ensure better preparedness, CMS should develop a core set of required elements tailored to specific local risks, the OIG said, adding that the agency should also encourage greater collaboration 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 benefit 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 Representatives passed H.R. 4, which would require the Secretary of Health and Human Services 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 Committee, 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 negotiate 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 director of the health program 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 physician services and many medical procedures, but setting prices for prescription drugs is a far more complicated proposition, 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 pharmaceuticals—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 negotiating drug prices will help solve other problems with Part D.

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

But the new Congress could design a workaround 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
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The clock is ticking for physicians to sign up for a National Provider Identifier, 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 after 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 required under the Health Insurance Portability 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 transactions, not just for billing Medicare or Medicaid. National standards like the NPI will make electronic data exchanges a viable 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 professional associations can submit applications for several physicians in an electronic file.

Officials at CMS are urging physicians who haven't yet signed up to do so soon. A physician who submits a properly completed 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 systems; 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 Whitman, senior analyst for regulatory and insurer affairs at the American College of Physicians. The application process itself takes only about 10 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 registered 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 1-800-465-3203 to request a paper application.