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LONG-TERM CARE

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Congress Grapples with LTC Coverage

by Herbert P. Weiss, N.H.A.

After prodding a reluctant Congress to pass a controversial five-year budget reconciliation package and NAFTA, the Clinton administration is now devising its strategy to enact its health care reform legislation on Capitol Hill. Even with other significant legislative initiatives planned for 1994, President Clinton is expected to direct considerable attention to and aggressively lobby for health care reform.

National opinion polls indicate that the American public would like the health care reform process to address long-term care. In fact, support for reform increases when long-term care coverage increases, according to a recent poll conducted for the American Association of Retired Persons. The poll also found that about 46.5 percent of those surveyed said they would be willing to pay $50 a month in higher taxes for national health insurance coverage that includes long-term care services.

Even with public support growing for long-term care reform, it is one of the least discussed and most costly new benefits being considered. Five prominent health care proposals are currently being circulated in Congress, with long-term care components (see chart on p. 3).

The President's Plan

Virtually all five proposals put the brakes on rising health care costs by

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(**Congress**, continued from page 1)

slowing the growth of Medicare and Medicaid, then using the savings to finance the reforms. But unlike most of the other proposals, President Clinton's plan (S.1757/H.R.3600) reinvests the money into new benefits for seniors and the disabled.

Savings under the plan would phase in funding for a new home and community-based long-term care program for severely impaired individuals regardless of age and income. The Clinton proposal also addresses the problem of residents "spending down" assets to become Medicaid eligible by increasing the asset protection limit.

In addition to the specific long-term care components of the Clinton legislation, it's important to note that only the Clinton plan and the McDermott/Wellstone plan propose a comprehensive solution to the devastating impact of high prescription drug costs on our nation's elderly. Elderly persons pay almost two-thirds of their prescription drug costs out of pocket, reports Families USA, a Washington, D.C.-based consumer watchdog group.

Under the Clinton plan, starting January 1, 1996, Medicare beneficiaries would be eligible for a new outpatient prescription drug benefit under Medicare Part B. After paying an annual deductible of $250 per person, beneficiaries would pay only 20 percent of prescription drug costs up to an annual maximum of $1,000. After 1996, the deductible and out-of-pocket maximum would increase only for inflation.

The comprehensive "single-payer" proposal offered by Rep. Jim McDermott (D-Wash.) and Sen Paul Wellstone (D-Minn.) would abolish Medicare and provide prescription drug benefits to all Americans.

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Alternative Proposals

The Republican health care reform proposal (S.1770), introduced by Senator John Chafee (R-R.I.), cuts about $200 billion from Medicare and Medicaid, but earmarks the savings to pay for vouchers for the poor, instead of new long-term care benefits. The Chafee plan keeps the existing long-term care delivery system in place, even with its problems. It does allow a personal tax deduction of long-term care expenditures as medical expenses (as does the Clinton proposal); however, this provision would generally provide little benefit to low income seniors.

For copies of the Senate bills, send a stamped, self-addressed envelope to: Senate Document Room, Hart Senate Office Building, Room B-04, Washington, D.C. 20510; for House bills, call the House Document Room at 202-226-3456. Copies of President Clinton's Health Security Act are available through the NARD Legislative Defense Fund by calling 703-683-8200 or 800-544-7447.

Spending cuts and increased Medicare premiums are the focus of Rep. Jim Cooper's (D-Tenn.) health care plan (H.R.3222). No new prescription drug or long-term care benefits would be added. If Cooper's bill becomes law, long-term care spending currently shared by the state and federal governments would be shifted entirely to the states by 1999.

Rep. Robert Michel's (R-Ill.) proposal (H.R.3080) caps Medicaid spending, giving states a per-person amount and no more, regardless of how much long-term care services actually cost. States also would have the option to cut back on long-term care services, reducing access to the needed service.

Under the McDermott/Wellstone proposal, seniors would pay a premium for a new basic benefit that includes home and community-based long-term care, personal care services, and nursing facility care.

In the Eyes of the Beholder

Critics of long-term care reform charge that its expense would derail congressional attempts to pass broader health care reforms. Some aging groups are concerned that new long-term care benefits may be "traded" for funding other worthy causes such as greater support for low-income women with children and other at-risk groups, says Paul Kerschner, Ph.D., executive director of the Gerontological Society of America.

Many people tend to view long-term care as only an aging issue. "It really is a family issue," says Kerschner, noting that many people would benefit from long-term care reform—children with birth defects, teenagers paralyzed by head traumas, young adults with multiple sclerosis, and older persons with Alzheimer's disease. "All of these individuals need and deserve access to long-term care services," he adds.

To recast the debate, 35 prominent health care and consumer groups recently rated the five major proposals on how they would affect families needing long-term care services. The coalition's "report card" offered a passing grade only to the Clinton and the McDermott/Wellstone proposals. The groups charged that the current system discriminates against people with chronic diseases and disabilities. Health insurance policies typically only pay for costly surgeries and treatments in physician offices and hospitals—not for long-term care provided in the patient's home. By paying for community-based services, the Clinton and McDermott/Wellstone proposals would remedy this reimbursement problem.

With the American public demanding action, not gridlock, the White House and Congress are poised to take up the complex issue of health reform. Many Washington insiders don't expect a comprehensive reform package to emerge intact. But a less-detailed proposal may emerge with a growing number of representatives and senators cosigning on more than one plan, and a president who has expressed a willingness to compromise.

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LTC
LONG-TERM CARE Pharmacist

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Vertical Integration Creates New Competitive Environment for Independents

There's a new kid on the block in long-term care pharmacy: the growing number of for-profit nursing facility chains that are moving aggressively into the area of pharmacy services.

For many facility chains, the decision to move into this marketplace is spurred by a desire to reduce their internal costs and "gain control" of their pharmacy services. But some facility chains also see pharmacy services as a new potential profit center. In other words, more and more chain-owned pharmacies are entering your marketplace—often by acquiring independent long-term care pharmacies—and they're even competing against you for your contracts with other nursing homes that aren't their own.

What's driving this trend? The primary factors appear to be the emerging subacute care market and the growth of managed care, both of which place higher demands on facilities in the area of information management. Subacute patients—who are primarily privately insured—tend to have greater need for round-the-clock pharmacy services than chronically ill elderly residents. In addition, like so many other health care providers today, nursing facilities are diversifying their operations to better weather the increasing pressure to lower their costs.

As one might imagine, this trend brings an interesting new twist to today's pharmacy marketplace. For example, pharmacies owned by a nursing home chain often must try to gain pharmacy contracts with competing nursing home chains. Or, in the case of facilities that have moved into the market by acquiring an independent pharmacy, they must fight to retain the pharmacy's existing contracts.

For independents, it's time to develop a new business strategy that recognizes this new breed of competitor and responds to the challenges of managed care—while still retaining the personalized approach that nursing facilities prize in independents.

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THIS Month

Final Rule on Rx Faxing

The Drug Enforcement Adminstration has issued a final rule on the faxing of prescriptions in long-term care facilities and home care.

Under previous DEA regulations, faxing of Schedule II prescriptions was permitted, but only if the original prescription was also obtained and verified against the fax before dispensing the medication. The new final regulation would allow long-term care dispensing pharmacies to maintain a faxed prescription of any Schedule II substance as the original prescription.

This "exception" to DEA regulations should "facilitate the delivery of medications to patients in long-term care facility settings where medication needs change quickly and physicians' orders need to be communicated rapidly," according to the new regulation. "By facilitating the process by which prescriptions are communicated, the need to treat them as emergency prescriptions...will be substantially eliminated."

A similar exception would be extended to home infusion or hospice pharmacies, but only for parenteral dosage forms of controlled-release narcotic substances. However, faxed prescriptions would not be considered the original prescription when dispensing oral dosage units of Schedule II substances.

A copy of the final regulation is available for Long-Term Care Division members by faxing a request to NARD at 703-683-3619.

(**Integration,** continued from page 1)

Competing Interests

How does a nursing facility decide whether to purchase pharmacy services from a competing company? "We don't want to be even remotely linked with a competitor nursing facility chain that does not share our corporate philosophy on quality of care and operating principles," says Sandra Wood, administrator of Fernwood Rehabilitation Nursing Center, a 100-bed facility in Bethesda, Maryland. She notes that affiliating with a nonreputable company could tarnish a facility's hard won reputation with its referral sources.

With more than 25 years of experience in managing nursing facilities, Wood sees important differences between independents and pharmacies that are owned by nursing facility chains. She says that while chain-owned pharmacies may promise lower drug prices and more information services, independent pharmacies are better able to personalize their services and are much more likely to be accommodating to special requests.

For example, if asked, an independent pharmacy might be willing to deliver medications and supplies at 10 p.m. five nights a week and 7 p.m. on the other two nights," Wood says. Chain-owned pharmacies are often more resistent to customizing their delivery schedule to fit this request.

Managed Care Demands Information

Managed care is reshaping the way pharmacy services are being provided to nursing facilities, and institutional pharmacies must adapt to these changes to survive, says Donna DeNardo, President of Vitalink, a Naperville, Illinois-based company that provides pharmacy services to 40,000 beds in 28 states. Manor Healthcare, the nation's third largest nursing-facility chain, owns 80 percent of VitaLink's stock.

As managed care gains a tighter grip on the health care delivery system, the most cost-effective pharmacy provider who can offer the broadest range of services will have the strength of servicing nursing facilities in years to come, DeNardo predicts. "Economies of scale give nursing home chain-owned pharmacies added purchasing power, and money to invest in computer information systems," she says.

According to DeNardo, patient information is of critical importance to nursing homes if they are to prosper in the era of managed care. "By investing in management information systems that allow us to access data and report it back in a meaningful way, we increase the value of service to our customers," she says.

"Small homes can also be hooked into an information pipeline by being affiliated with a pharmacy owned by a large nursing home chain," DeNardo claims, adding that their research and development efforts enable these smaller homes to plan for regulatory and reimbursement changes.

Mastering the Rules of the New Game

Mayer Handleman, owner of Woodhaven Pharmacy and Institutional Services, an independent pharmacy, concedes that some pharmacies operated by nursing home chains may have an edge over their competition in providing useful information to client facilities. With the right software, however, independent long-term care pharmacies can generate the same information—and deliver it with the kind of personalized service that independents are known for.

Software packages that help nursing facilities do their job better increase your level of service. "We have put some programs in to help our facilities cope with the growing information demands of managed care companies," says Handleman. Woodhaven, of Towson, Maryland, generates reports each month listing the most commonly used drug classes, how much has been spent by drug class, and the cost per patient.

Personalized service also means quick decision-making, an area where independents have a clear advantage, Handleman claims. "We don't have to go back to corporate headquarters for an answer. We can give a response immediately—on the spot," he notes.

"Revenue sharing" programs are another way to provide better service to your clients, adds Marvin Richardson, president of Low Cost Health Care in Indianapolis, Indiana, which provides pharmacy services to more than 1,500 residents in 13 facilities. For example, when Low Cost provides enteral nutrition products to nursing homes, facilities can contract with Low Cost to do their Medicare Part B billing for a set charge per patient.

"The facilities can choose whether to do the billing themselves, or pay us to do the billing either under our own supplier number or under the facilities' supplier number," Richardson explains. Many facilities take advantage of this service to avoid the expense and hassle of hiring and training billing staff that knows Part B billing and does it well.

The dynamics of the private insurance market are also affecting pharmacies and facilities alike. "As managed care plays a greater role in the health care system, we'll continue to see our profit margins squeezed," Richardson predicts. "Those that operate effectively and control expenses and provide quality services will survive."

But ultimately, Richardson supports Handleman's contention that good service will give independent long-term care pharmacies a competitive edge over their better financed competitors. "It's not doom and gloom" for independents in long-term care, Richardson says. "Those who change and adapt will continue to grow and retain their market shares. However, those pharmacies who continue to do business like they did ten years ago won't survive."

By Herbert P. Weiss, N.H.A., a Providence, Rhode Island-based freelance writer specializing in health care and aging issues.

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Large Institutional Pharmacy Providers Move to Capture Market

If it seems to you that "the big fish are swallowing the little fish" with increasing frequency in today's institutional pharmacy market, your impression is probably right on target. Although the long-term care market is still marked by hundreds of companies competing to provide pharmacy services to nursing homes, consolidation is beginning to escalate at a dizzying rate of speed. For-profit nursing facility chains (see July, 1994 *LTC Pharmacist*) and larger independent long-term pharmacy providers are not just competing for nursing home contracts, they are buying up whole companies to expand their business.

THIS Month

The trend toward consolidation in the long-term care pharmacy marketplace began less than a decade ago with the enactment of sweeping nursing home reform provisions mandated by the Omnibus Budget Reconciliation Act of 1987. When these provisions became federal law in 1991, they required institutional long-term care pharmacies to offer certain sophisticated services—such as drug-drug interaction studies and drug utilization reviews—to their nursing home clients. In order to comply with the new federal mandates and to more effectively retain or expand their market share, many retail pharmacies were forced to evolve into companies that specialized in providing nursing home pharmacy services—or, to sell out to larger companies.

Fueling the Trend Toward Consolidation

According to Leonard Jaffe, M.D., a health care analyst at Montgomery Securities in San Francisco, several escalating trends will continue to fuel the fires of consolidation for years to come. Among them are:

- The emerging subacute care market, which requires pharmacies serving nursing homes to provide intravenous treatments and other specialized services to sicker patients
- The growing number of nursing home chains that now operate pharmacies for their own facilities
- The rising popularity of managed care
- A growing elderly population

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DMERC Fraud Unit Targets Marketing Scheme

The Region A durable medical equipment regional carrier fraud and abuse unit has uncovered a scheme involving the marketing of incontinence kits to nursing homes. The DME supplier who has been marketing the kits apparently has claimed that nursing home patients who are covered under Medicare Part B and who have a diagnosis of urinary incontinence (ICD-9 Code 788.3) qualify for the kits.

In some cases, the seller reportedly has claimed that Medicare is paying for the kits under a special pilot program. Reportedly, beneficiaries are told to ignore the copayment if they do not have insurance.

Although there seems to be some variation in the contents of the kits, they usually include most of the following items:

- Latex exam gloves (A4927)
- Sterile saline (A4214 or A4323)
- Syringe, 60cc, prefilled with Peri-Wash (A4213), or Irrigation Syringe (A4322)
- Skin Barrier: Liquid, Powder or Paste (A4363)

The marketing program for the kits states that the treatment should be three times a day; whether or not the patient has an indwelling catheter does not seem relevant. Each patient apparently receives the same supplies. The DMERC Fraud Unit will be reviewing claims for incontinence kits and supplies to ensure Medicare program guidelines are met.

(**Market**, continued from page 1)

"There are currently 1.6 million nursing home beds in the United States, with nursing home chains providing pharmacy services to about 20 percent of that market, or 320,000 beds," Jaffe calculates. "Right now, consolidation appears most likely to take place in the southern part of the country, where many chain facilities are located."

In one recent buyout, Brockton, Massachusetts-based Syntec, Inc., which services an estimated 40,000 beds, was purchased by Beverly Enterprises, the largest nursing home chain in the nation. And, even as a growing number of nursing home chains move aggressively into the long-term care market to compete for nursing home contracts, a handful of large independent long-term care pharmacies continue to gobble up smaller pharmacies at a rapid rate.

NCS HealthCare in Acquisition Mode

Ohio-based NCS HealthCare, a company that provides services to 25,000 nursing home beds in Ohio, Michigan, and Pennsylvania, has been in an expansion mode for the last several years. "We're looking to purchase independent institutional pharmacies in our existing markets, and we also plan to initiate growth in new geographic areas, specifically in Indiana and Kentucky," says NCS Vice President Suzanne Eastman.

Acquiring existing pharmacies is a prime strategy NCS HealthCare is using in order to stay competitive in the new health care environment, says Eastman. "It is important for us to expand in our seven-state regional marketplace, because we want to be able to compete for managed care contracts."

According to Eastman, funds have been allocated by her company to purchase existing long-term care institutional pharmacies. "The individual situation will dictate our strategy for purchasing companies," she says. NCS HealthCare has plans to approach 15 companies this year to offer bids or to gauge the companies' interest in selling.

NCS HealthCare is looking at a 25 percent growth rate this year, both through buying existing pharmacies and by expanding its current client base through obtaining more accounts.

"Until the year 2050, the outlook is for above average growth of institutional long-term care pharmacies."

Omnicare: Leader of the Pack

Omnicare, the largest of the independent institutional pharmacy companies, has grown tremendously over the last six years, says Senior Vice President Cheryl D. Hodges. Today, the Ohio-based company services 126,300 beds in 1,450 nursing facilities in 10 states. About 27,400 of those beds were added through aquisitions last year. When negotiations are completed for the purchase of Evergreen Pharmaceutical, Inc., in Seattle, Washington, Omnicare will serve 137,500 beds in 1,570 facilities in 13 states. The company is exploring the purchase of at least 15 companies this year.

According to Hodges, Omnicare's strategy for growth involves acquiring existing companies to gain additional regional market share. While the company has so far spent 25 million to 40 million to buy out competitors, it expects to exceed that amount this year, she says.

"We have concentrated on companies with good operating results—not the 'fixer-uppers,' which would deflect management's time and effort," Hodges says. "Also, we look for a cultural fit between the managements of both companies." Hodges claims that smaller pharmacies that have been consolidated into Omnicare have benefitted from being able to offer more sophisticated services to their clients.

A Booming Industry

Jaffe predicts that the institutional pharmacy sector will grow from a $2.5 billion dollar industry in 1991 to $4 billion dollars by 1996. He adds that health care expenditures are expected to increase by 6 percent, compared to a growth rate of about 12 to 15 percent for institutional long-term care pharmacies. "I would argue that until the year 2050, the outlook is for above average growth of the institutional long term care pharmacies, especially with a rapidly growing elderly population," says Jaffe.

By Herbert P. Weiss, a Providence, Rhode Island-based writer specializing in health care and aging issues.

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Look Before You Leap: Be Prepared Before You Enter the Subacute Care Market

In the past five years, a growing number of nursing facilities have jumped into the $4 billion subacute care market. Health care analysts currently estimate the number of subacute beds in this country to be between 10,000 and 15,000—and the number is growing.

But before making the leap into this promising market, independent pharmacy providers are well advised to take stock of their resources and become familiar with some of the unique challenges and opportunities of providing pharmacy services to subacute care units. To be competitive in this emerging market, your company must adapt itself to providing pharmacy services to a whole new patient population—acute-care patients who require extended skilled medical or rehabilitation services.

THIS Month

Subacute care aims to lower costs while maintaining quality of care by combining high tech hospital treatments with the efficient operations of a nursing facility. According to a recent Dean Witter report, cost differences for the same patient can range from $700 to $1000 a day at an acute-care hospital, through $850 a day at an acute rehabilitation hospital, to $300 to $550 per day at a subacute care facility.

No More Business As Usual

"Business as usual" is not a good operating philosophy for those who want to compete in the world of subacute care, warns Steve Coffey. Coffey is the pharmacy manager for Pharmacy Corporation of America, a national company that provides pharmacy services to 65 nursing homes in Rhode Island.

According to Coffey, pharmacy providers must tailor their drug distribution schedules and consulting services carefully to fit the needs of subacute care patients. "Multiple deliveries per day are often required, because patients are admitted more quickly and require more medications," he told *LTC Pharmacist*.

Patients are being admitted to subacute care units around the clock and on weekends, Coffey noted. Pharmacy providers

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Rooting Out Fraud

The new chairman of the Senate Aging Committee has proclaimed his intention to mount a "no-holds-barred" effort to halt Medicare and Medicaid fraud, claiming that the federal government loses billions of dollars a year to fraud and abuse. Saying that anti-fraud efforts will be his number one priority, Senator William Cohen (R-Maine) has already introduced a bill to beef up law enforcement efforts designed to crack down on fraud in federal programs.

S.245, the "Health Care Fraud Prevention Act of 1995," would, among other things, expand existing criminal and civil penalties for health care fraud. The major anti-fraud provisions of the Act fall into the following categories:

- A new all-payer fraud and abuse control program, with new mechanisms for providing guidance to providers on anti-fraud statutes
- Revisions to current Medicare and Medicaid fraud and abuse sanctions
- Civil monetary penalty provisions
- Amendments to criminal law

One interesting aspect of the legislation is a provision to provide additional guidance to providers in interpreting federal health care fraud and abuse laws. The Act would also allow individual providers to request special fraud alerts and interpretive rulings at any time. Sen. Cohen's legislation would establish state Health Care Fraud and Abuse Control Units similar to the current state Medicaid Fraud Control units.

(**Subacute**, continued from page 1)

must be able to schedule deliveries during these hours. He added that while pharmacy providers usually visit a skilled nursing facility on a monthly basis to review drug regimens or therapies, weekly site trips are required for subacute care, due to the patient's higher acuity level and shorter stay.

More Complex Care

A typical patient will stay in a subacute care unit from seven to fourteen days. "The patients are sicker, and their drug regimens are continually being changed to stabilize their medical conditions," said Coffey. "Physicians are constantly looking to the consultant pharmacist for help in making treatment decisions regarding dosages, proper drug usage, and the monitoring of laboratory reports," he added.

Coffey noted that with the complexity of medical care being provided to subacute care patients, the emergency medication kit must be filled with a larger quantity of injectable and oral medications such as nifedipine, furosemide, and digoxin for cardiac patients.

In order to allow nursing staff to immediately start a subacute care patient on medication, the medication kit must be fully stocked at all times with respiratory, cardiac, and seizure medications.

New JCAHO Standards

Because of the increasing number of facilities offering subacute care services, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) has created standards for subacute care, said Dianne Tobias, Pharm.D., corporate director of quality improvement for Regency Health Services. The California-based company provides nursing home services to approximately 100 nursing homes, many of which have subacute care units.

"JCAHO's new pharmacy standards for subacute care patients reflect the fact that sicker patients require more intense monitoring by the pharmacist," said Tobias, who serves as vice chairman of JCAHO's Professional and Technical Advisory Committee for Long Term Care.

"JCAHO standards also recognize that you may not be able to rely on a retrospective drug regimen review alone when treating subacute care patients," Tobias said. With this type of patient, pharmacists may need to spend more time at the unit, increase off site consultative time, and work more closely with the dispensing pharmacist. Traditional consulting does not meet the needs of subacute care patients, she said.

According to Tobias, depending on the type of subacute care services provided, the degree and type of monitoring will vary. "Some IV therapy may require pharmacokinetic monitoring and consultation by the pharmacist," she pointed out.

Tobias brought up one other factor to keep in mind when considering the subacute care market. She noted that as more subacute care beds fill up with managed care patients, pharmacy providers must become partners with nursing facilities in tracking outcomes data.

Consultant pharmacists can help facilities track outcome and financial data, specifically costs of medication, Tobias suggested, noting that managed care groups demand this information to document that the patient is receiving the appropriate level of care.

As more subacute care beds fill up with managed care patients, pharmacy providers must become partners with nursing facilities in tracking outcomes data.

What is Subacute Care?

Nursing home subacute care units offer a wide variety of medical, rehabilitative, and therapeutic services, at levels of quality comparable to that of hospitals. Medical conditions treated in a subacute care unit can include:

- Ventilator and tracheostomy care
- Chemotherapy and pain management for oncology patients
- Dialysis
- Intravenous therapy
- Wound care management
- Telemetry for cardiac patients
- Head trauma
- Hip fractures
- AIDS
- Neurological and respiratory problems
- Brain and spinal cord injuries

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MDS Garners Rave Reviews

Representatives of nursing home and consumer groups gave a four-star rating to the Health Care Financing Administration's latest draft version of the Minimum Data Set.

The agency unveiled its final draft of the long-awaited resident assessment tool before more than 150 attendees of a three-day training session held in Baltimore in February.

HCFA was expected to officially publish the final MDS 2.0 in the state operations manual later this spring after incorporating comments gathered at the meeting, according to a HCFA official responsible for MDS implementation. By January 1, 1996, states must use the 2.0 version, unless HCFA grants an extension. Facilities will then be required to use the assessment tool for new admissions, annual assessments, quarterly reviews, and documentation of significant changes in resident health status.

THIS Month

The HCFA official said that MDS 2.0 will be the foundation for the agency's plan for a data-driven survey process that targets potential care problems and focuses survey activity.

HCFA said it plans to release a second edition of the resident assessment instrument training manual by August, along with videos and train-the-trainer packages.

HCFA developed the revised assessment instrument by taking into consideration about 150 comments on the proposed MDS rule, information from long-term care industry experts, and field-testing at 30 nursing homes, the HCFA official noted.

Revisions include an addition to the MDS and almost twice as many quarterly review items. In addition, HCFA rewrote the "mood state" section of MDS 2.0 to ensure usefulness and reliability for clinicians. The revised assessment instrument also requests clinical information on pain, balance, treatments, and rehabilitation.

HCFA said it plans to add and revise resident assessment protocols to address the needs of the short-term stay population. The agency also said it expects the first new resident assessment protocol to have a "discharge potential," with additional protocols to include pain management, terminal care, and bowel incontinence.

"It is a very well-thought-out instrument that provides wonderful information for care planning," said Sarah Burger, policy and program associate for the National Citizens' Coalition for Nursing Home Reform, Washington.

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Purchasing Group Merger Creates Nation's Largest GPO

MedEcon Services, Inc., and GeriMed Inc., two of the nation's largest group purchasing organizations (GPOs), have merged to form the largest single GPO in the United States. The two organizations, both based in Louisville, Kentucky, jointly account for an estimated $3.6 billion in annual purchasing volume.

MedEcon Services, formed in 1971, is a GPO offering a broad base of health care purchasing programs. MedEcon operates in 44 states, with reported membership of over 4,500 facilities.

GeriMed, formed in early 1983, is part of the MedGroup, a holding company which operates in all 50 states and services 604,568 long-term care beds.

"Most people probably don't remember that GeriMed was originally a joint venture with MedEcon back in early 1983," said Joe Schutte, president of GeriMed. Schutte said the newly formed entity plans to attack pharmacy costs in every delivery modality, including acute care, long-term care, alternate care, home health infusion, and retail.

"In this vertically integrated market, vendors struggle to capture volumes," said Schutte. "This new GPO will give vendors efficient access to market share."

The new corporation created by the merger acknowledges an ongoing acquisition posture. "We will evaluate all business opportunities in this marketplace, and move aggressively," said MedEcon Chairman William Wooldridge.

(**MDS Reviews**, continued from page 1)

HCFA said it expects to publish the final rule requiring facilities to encode and transmit the MDS 2.0 to a central repository in late 1995, with implementation in 1996.

Results from a survey conducted by the American Health Care Association have shown that about 62 percent of providers have already computerized their resident assessment process.

—reprinted , with permission, from McKnight's Long Term Care News, *vol.16, no. 4.*

Federal Study Examines Wound Care Marketing Practices

The Office of Evaluation and Inspections of the U.S. Office of Inspector General has initiated a study of marketing practices of suppliers providing wound care products to residents of nursing facilities. The OEI is the component within the Office of Inspector General that conducts short-term studies designed to determine program effectiveness, efficiency, and vulnerability to fraud and abuse.

The OEI distributed a 14-page questionnaire to a random national sample of 420 nursing facilities. The questionnaire asks for information about marketing practices of suppliers who provide surgical dressing and wound care products to Medicare Part B patients during their stays in nursing facilities. The survey does not include wound care supplies or surgical dressings that are included in Part A cost reports.

Nutrition Problems Related to Medication Use in the Elderly

Drug or Drug Group	Nutrition-Related Problem
Digoxin, Captopril, NSAIDs	Decreased Appetite
Anti-Parkinsonism drugs and other drugs having anti-cholinergic effects	Dry mouth
Captopril; Penicillamine	Decreased taste perception
Methotrexate	Decreased ability to swallow
Aspirin, NSAIDs	Iron deficiency anemia
Phenytoin, Sulfamethoxazole+ trimethoprim (Bactrim), Sulfasalazine	Folate deficiency with anemia
Furosemide	Thiamine deficiency with congestive heart failure
Digoxin	Protein-energy malnutrition
Antihistamines	Dry mouth, loss of appetite
Laxatives	Potassium deficiency, malabsorption
Antacids	Phosphate depletion, muscle weakness, osteomalacia
Analgesics (aspirin and ibuprofen)	Anemia

Source: National Screening Initiative, Nutrition Interventions Manual for Professionals Caring for Older Americans.

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White House Conference on Aging Addresses Medicare, Social Security, Prescription Drug Coverage

Delegates to the fourth White House Conference on Aging last month sent a clear message to federal policymakers: Preserve and maintain Social Security and provisions of the Older Americans Act, prevent arbitrary cuts in the Medicare program, and oppose block granting for the Medicaid program. The delegates also called for universal health coverage, further development of home and community-based services, and reforms of the health care system that would include prescription drug coverage for Medicare beneficiaries.

Two thousand delegates gathered in Washington, D.C. May 5 to discuss problems faced by 33 million older Americans and to develop resolutions that will influence the nation's policy debates regarding aging issues for the next ten years. Fifty resolutions were adopted during the conference.

Although the resolutions are not legally binding on the president or on Congress, they provide a forum for older Americans to tell the nation their priorities, said Robert D. Blancato, executive director of the conference. Blancato noted that the report from the conference will be submitted to the president and Congress around

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THIS Month

Top Ten WHCoA Resolutions

1 Keep Social Security sound for now and for the future

2 Preserve the integrity of the Older Americans Act

3 Preserve the nature of Medicaid

4 Reauthorize the Older Americans Act

5 Increase funding for Alzheimer research

6 Preserve advocacy functions under the Older Americans Act

7 Ensure the availability of a broad spectrum of services

8 Finance and provide long-term care and services

9 Acknowledge the contribution of older volunteers

10 Assume personal responsibility for the state of one's health

(**Aging**, continued from page 1)

the beginning of 1996.

Though some conservative groups charged that the "wish list" of final resolutions emerging from the conference would be too costly to implement in these belt-tightening times, WHCoA Policy Committee Chairman Sen. David Pryor (D-Ark.) disagreed, calling the delegates "pragmatic" and pointing out that their recommendations did not support any new programs or create any new bureaucracies.

Turning Up the Heat

Medicare, the hottest political issue on Capitol Hill since health reform, took center stage at the WHCoA as Vice President Gore characterized efforts to modify Medicare as a veiled effort to provide tax cuts to the wealthy.

Although Gore recognized that House Speaker Newt Gingrich (R-Ga.) had pledged to remove Medicare from the budget process and had called for all Medicare savings to go back into the program, he pointedly noted that other House Republicans had called for slashing Medicare by $300 billion over seven years to cut the federal deficit; Senate proposals would cut $250 billion.

Gore warned that this action translates to $3,500 in additional out-of-pocket costs for the average Medicare recipient.

Delegates applauded when President Clinton began his opening address by stressing that government had a "moral responsibility" to protect Medicare. The president asserted that he would never allow Congress to gut the Medicare program in order to pay for tax cuts for the wealthy.

Clinton went on to claim that the right way to reverse the threatened bankruptcy of the Medicare trust fund within seven years is to strengthen Medicare and Medicaid programs by containing costs through broad health care reforms—not by reducing coverage, forcing beneficiaries into managed care programs, and reducing benefits to pay for tax cuts.

Operation Restore Trust

During his WHCoA address, Clinton unveiled a new initiative to crack down on Medicare and Medicaid fraud and abuse in home health agencies, in nursing homes, and among suppliers of durable medical equipment.

"Operation Restore Trust" will initially focus on five states—California, Florida, Illinois, New York, and Texas. Nearly 40 percent of all Medicare beneficiaries live in those states.

A voluntary disclosure program will allow home health and nursing home providers to come forward with evidence of fraud and abuse in their own organizations in exchange for possible reduced penalties. A special hot line will allow the public, including Medicare and Medicaid beneficiaries, to report fraud and waste.

A Pharmacist's View

Many delegates to the WHCoA—especially those over age 50—seemed unaware of the key role that pharmacists play in treating elderly patients, said a surprised Holly Strom, R.Ph., of Los Angeles, California, one of four pharmacists attending the event.

Strom added that many delegates did not even know that federal law requires a monthly monitoring of the drug regimen of each skilled nursing facility resident by a pharmacist. "When they heard about the requirement, they wanted the service expanded to ambulatory seniors, too," she noted.

Strom said that pharmacists attending the conference worked as a team to get delegates to support Medicare reimbursement for pharmacy services for ambulatory seniors. "This is sound public policy because it reduces the occurrence of drug misadventures that result in costly hospital and nursing home admissions," she said. Strom noted that one of the resolutions adopted at the conference calls for prescription drug coverage for Medicare beneficiaries.

Congress should take a closer look at this resolution, said Strom, because seniors use over 35 percent of the nation's prescription drugs, while making up only 12 percent of the nation's population.

"When Congress moves to introduce legislation to implement this resolution, we must push for pharmacy services to be included," said Strom. However, she warned, Congress will have to move fast. "We don't have much time left before we have to take care of a massive aging population," she said.

—By Herbert Weiss, a Providence, Rhode Island-based writer specializing in health care and aging issues.

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Update on Antiepileptic Drugs

Epilepsy can have a significant impact on a patient's life, and treatment must frequently be life-long. Drugs such as phenytoin (Dilantin), phenobarbital, primidone (Mysoline), valproate (Depakene, Depakote) and carbamazepine (Tegretol) have been used successfully for many years, but are not completely effective for all patients and can be associated with significant side effects.

The search for new antiepileptic drugs has therefore continued. When felbamate (Felbatol) was approved by the FDA in July, 1993, it was the first new antiepileptic drug to be approved for use in the U.S. since 1978. It was followed by gabapentin (Neurontin) in December, 1993 and lamotrigine (Lamictal) in December 1994.

A summary of the labeled indications, dosage forms available, and examples of side effects of the older antiepileptic drugs and the three new drugs is presented on the following page.