VIRGINIA'S MEDICAID PROGRAM
DMAS
INNOVATION • QUALITY • VALUE
Department of Medical Assistance Services
Dual Eligible Financial Integration Demonstration
Nursing Facilities and Hospitals
March 21, 2012
http://dmasva.dmas.virginia.gov
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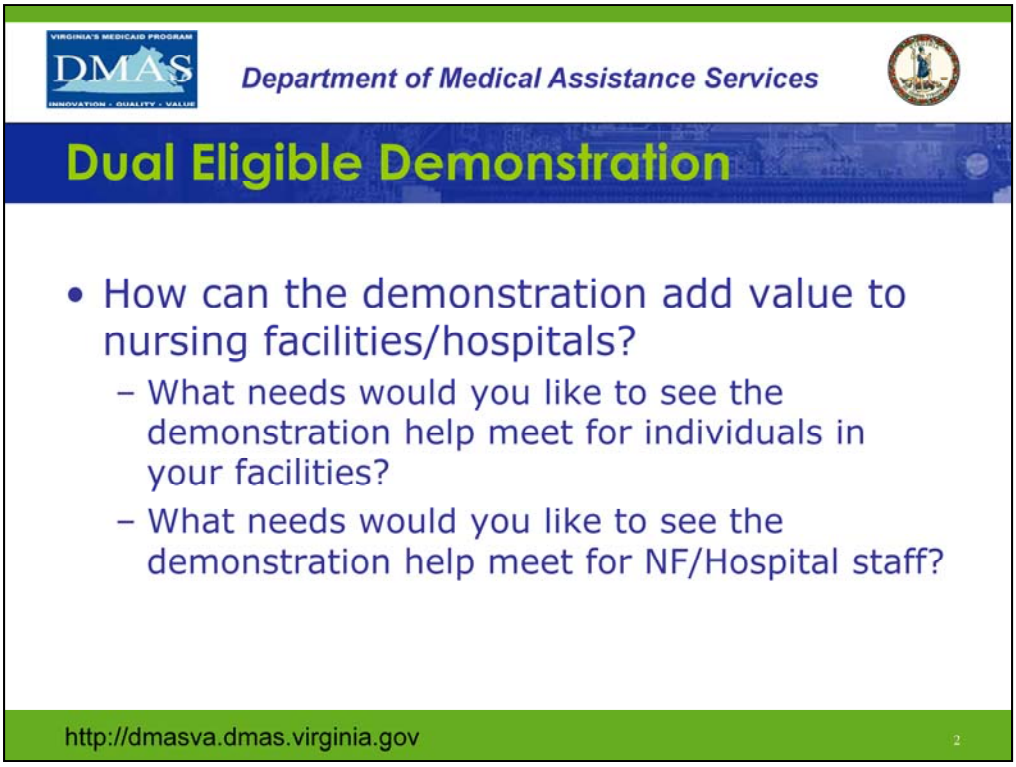
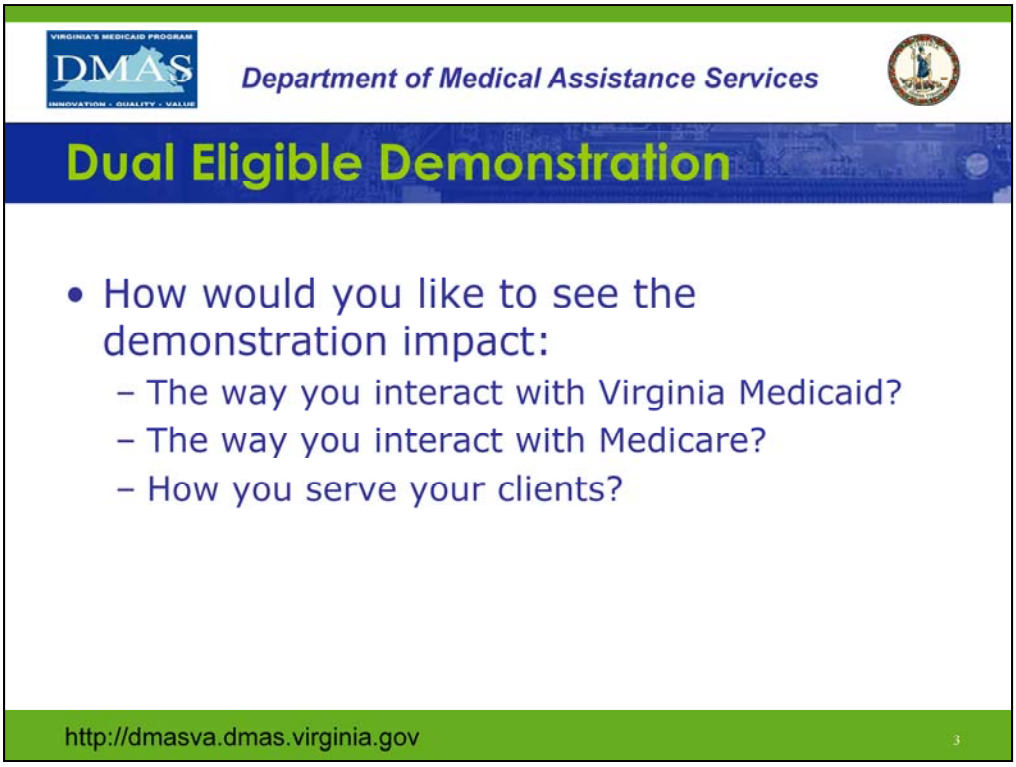
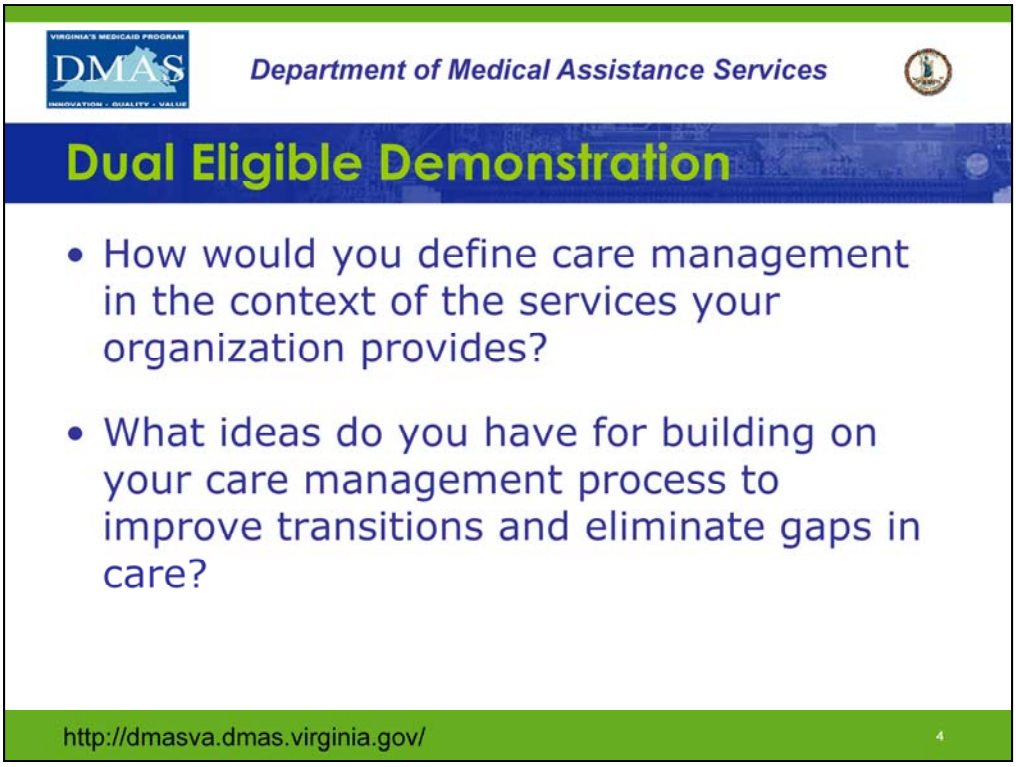


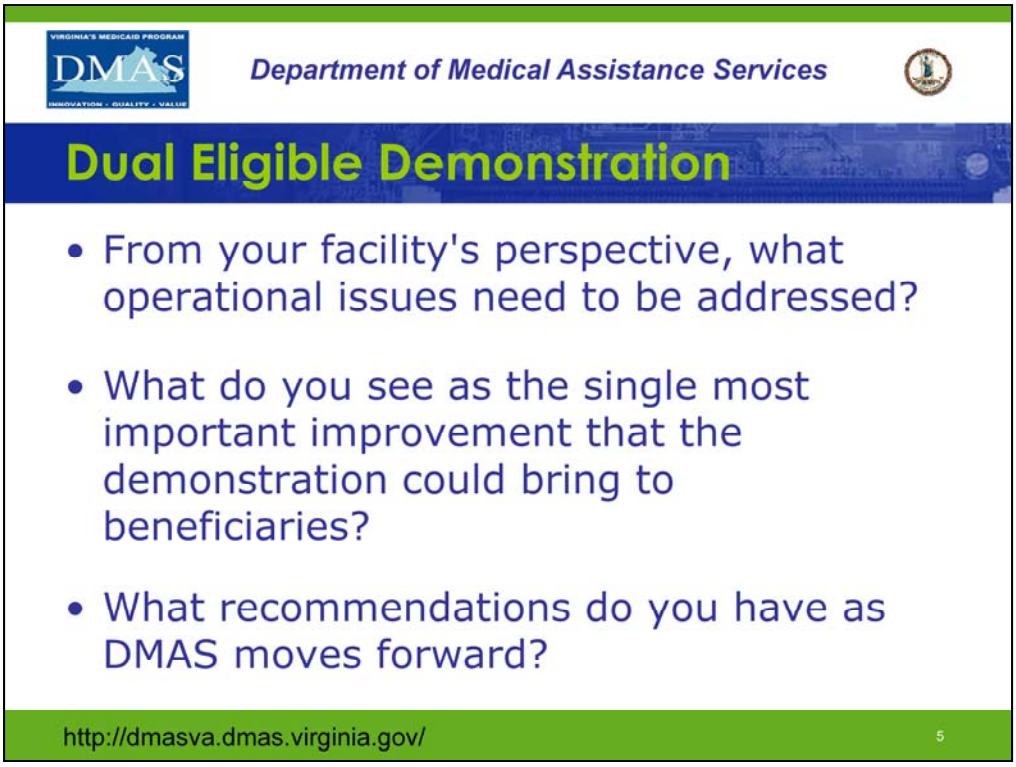
- Nursing facilities struggle with providing dental care to residents – MAP adjustment to cover services – system doesn't work very well – need more comprehensive coverage
- Struggle with BH issues - have problems finding providers to come into the nursing facilities - need help with obtaining resources/providers for patients
- Case mix index for BH – NFs are required to have similar staffing patterns – hope this can be recognized by the health plans – different than long term care unit staffing
- Resources to manage BH needs of person - transportation of patients to doctors and appointments outside facility – not good/safe process – needs to be revisited
- NF caring for residents that have an acute health event – typically transported to ER – NFs not equipped to address event –goal is not to eliminate but avoid ER admission - change how communicate with hospitals – e.g. telemedicine – hire NP, PAs and resources inside facility
- Hospital/health systems – value add would be better real time data on patients – pool Medicare/Medicaid data – daily updates and feed in consistent, accessible tool - challenge to do in capitated environment – degree of collaboration on data sharing – encourage plans to support locally embedded resources for patients – need case managers, PhD, palliative care – create incentives for resources
- No margin, no mission – NFs are not reimbursed the actual cost for care we are delivering under Medicaid – some margin under Medicare which helps offset Medicaid losses
- Include specific requirement for telehealth use - could be useful for behavioral health services (e.g., some psych services) – need to explore this option in more detail



- Providers have anxiety and don't want to see change in relationship with DMAS – concern model will dramatically change things – enjoy the listening ear on phone – nature of Medicaid/NF relationship in other states adversarial – see relationship continue when working with health plans
- Communication – make sure clear form of communication –interpretation of rules and regs (preadmission) – open communication as this is rolled out
- Patients come from hospitals with Medicare eligibility provided – how will UAI process be impacted?
- PACE site physicians don't worry about Medicare, Medicaid rules but what patient needs – way we act with Medicare, Medicaid, providers should not have to worry about rules – delegated freedom – mutual agreement on goals for population – hold accountable – not micromanage – same goals that plans and providers and community shoot at common targets
- Urge for MCOs to consider importance of relationships to achieving outcomes to manage care and dollars – trust nursing homes and staff – collaborative partnership
- 3 day qualifying stay has outlived its useful life – needs to go away
- Critical to balance dynamic between Medi/Medi – MCOs must understand so as not to place provider community at risk
- IMD and freestanding psych facilities – need to waive this prohibition
- BH – could LTC environment manage BH – look for BH solution embedded in facilities
- Care management in LTC facility – increased cost if involved in care management - adds admin costs to facility – cost sharing to have effective care management
- Any way to look at those discharge back to community to incorporate navigators, coaches – create model for follow through once they get home



- NFs do interdisciplinary care plans regularly – lot of value of how plans are done in the facility taking into account complex pieces
- Financial incentives around readmits – responsible for follow-up care so they don't come back – working hard to improve readmit patterns – build into demo that remains cognizant of incentives and tools that are being built now – collaborations in each region of the state
- Aftercare monitoring – who pays for it and what will they pay for? LTC has nurses around the clock, but home health is not 24/7
- Medicaid bed hold day – return to facility after hospitalization – put on the list
- Family that insist patient go to hospital even when NF suggest they not – how will plans and NFs handle? NFs face lawsuits if they don't listen to families
- Re-emphasize need for robust network – ensure sufficient number of providers in demo - Where to place patients, especially those that are "hard to discharge"?
- Real time data and exchange of info to help improve hand-offs
- Clinical data sharing and HIPAA issues – complicated process – need help to bridge to get real time data
- Inclusion of capital and expenditures for infrastructures smaller organizations don't have in place



- Less regulations – model to focus on patient until come in and they go back home – open form of communication for issues with health plans and all taking care of patient – have it work for all involved
- Putting patient first
- Reduce silos. MCOs can be involved in silos as long as information exchanged timely and accurately - huge improvement in transfers between settings of care
- Use enhanced technology to monitor residents
- Take advantage of other investments being made in data sharing – HIE and support HIE related to dual population – tools for sharing of info on the population
- Dealing with regs and survey and another person in mix to determine care impacts the survey process
- Include clarification of DMAS' LTC and role in this process

Letters of Support

DMAS is gathering letters of support to include with the proposal package. Letters of support must be included in the proposal sent to CMS by May 31. Please send your letter of support to DMAS care of Cindi B. Jones by May 20, 2012 but address to the letter to:

Melanie Bella
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Proposal comments and letters of support may be sent to DMAS electronically at dualintegration@dmas.virginia.gov or to DMAS 600 East Broad Street, Richmond, VA 23219. Your support is greatly appreciated.