Email to DHS Deb Rathermel from Tom Lutzow, iCare

Sent: Wednesday, May 09, 2012 6:39 PM

From: Tom Lutzow [mailto:tlutzow@icare-wi.org]
To: Rathermel, Deborah L - DHS

Subject: Virtual PACE Policy-Change Recommendations

Greetings Deb,

In iCare's meetings with a number of nursing home executives, we understand that the following policy-change recommendations might increase their interest in the Virtual PACE Initiative. These recommendations are not prioritized:

- Coverage for DME services would be assured, including all appropriately proscribed orthotics and prosthetic devices necessary to meet the patients needs (periodically nursing homes will be stuck with the bill for prosthetic devices related to an acute episode but provided post acute while a nursing home patient).
- Rates would use the Medicare and Medicaid RUG and MDS assessment protocols as established by the state or federal government for determining payment rates.
- Savings would be generated through utilization efficiencies rather than rate cutting.
- Wound vac treatments when clinically appropriate would be covered.
- Prior authorization requirements for the first week post admission would be waived.
- Clean claims would be paid within 30 days with interest applied to late payments.
- Clinitron or air fluidized therapy services when clinically appropriate would be covered.
- Transportation for non-emergent medical services not able to be provided in the nursing center would be covered.
- Part B buy-in for all dual eligible participants would be part of the Medicaid coverage .
- Clearly defined protocols would be established for determining when a patient is given services in lieu of rehospitalization and reimbursement at the Medicare rate (Medicare rates may need to be adjusted to remove separately coverable non-therapy ancillary services listed below).
    - Nursing homes would be exempt from pharmaceutical responsibility and coverage would be under part D or on a cost base basis like long term care acute hospitals, special note for chemo therapy, drugs related to transplant recipients and IV antibiotics
    - Nursing homes would be exempt from cost responsibility for certain consolidated billing requirements for cancer and other medically necessary treatments provided in freestanding clinics (coverage equal to services provided in the hospital based clinics) (this could also lower costs for the insurer as lower cost services could be utilized to meet patient needs)
- Enhanced clinical skill support would be made available to meet needs of patients diverted from rehospitalization – advance practice nurse, physician or other clinical specialist.

- Nursing home staff would participate in a patient's ICO interdisciplinary managed care team.
- Ventilator program design would be revised to encourage development of weaning or partial weaning programs for patients currently in an acute setting, programs would include intensive respiratory therapy, involvement of a pulmonologist and partnership with a hospital. Possibly consider a patient specific negotiated rate based upon a documented plan of care and treatment.
- Enrollment in Virtual PACE would initiate with the expiration of Medicare skilled nursing coverage for the current benefit period rather than day 101.
- Role hospice bereavement and social services into the skilled nursing center as part of the ICO function for clients.
- Prioritize processing the application of nursing home patients applying for Medicaid that are currently Medicare eligible to eliminate or minimize any retroactive issues.
- Rate enhancements would occur based on projected Medicare savings in year two of the program.
- Technical assistance program would be made available to providers not meeting expectation on avoiding hospital admissions, working with center staff and practicing physicians.
- Medicaid rate incentive for centers involved in the Virtual PACE program who hire a nurse practitioner to work in the center (the incentive should be sufficient to offset the cost for a center with a minimum census of 50 Medicare patients). Government supported centers would not be eligible for the incentive.
- The process for care planning would be clearly defined and the state would accept this defined approach as satisfying the conditions of the annual survey and certification process.
- Nursing homes would acquire the same conceptual and programmatic value as medical homes in the continuum of care.

This list is not exhaustive. Other policy-change recommendations may be suggested in the near future, and even during the operation of the program. Perhaps the DLTC would consider these policy-change recommendations in its initial design of Virtual PACE.

Regards,
Tom Lutzow

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