Approved: January 16, 1996
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans at 1:30 p.m. on January 10, 1996 in Room 423-S of the State Capitol.

All members were present

Committee staff present: Norman Furse, Revisor of Statutes
Bill Wolff, Legislative Research Department
Francie Marshall, Committee Secretary

Conferees appearing before the committee: Rochelle Chronister, SRS Secretary

Others attending: See Guest List, Attachment 1.

The meeting was called to order by Chairperson Mayans with an open invitation to stop by his office. A new member, Representative Geraldine Flaharty, from south central Wichita was introduced to the Committee.

Chairperson Mayans introduced a concurrent resolution providing coverage of maternity benefits for inpatient care following delivery of a new born for obstetrical care up to 72 hours (see Attachment 2). Representative Wells expressed concern that each individual be a different case and handled by the Doctor on an individual basis. After discussion, Representative Morrison moved to accept the resolution, and it was seconded by Representative O'Connor. The committee approved by voice vote .

Chairman Mayans introduced Rochelle Chronister, SRS secretary, who in turn introduced seven of her Commissioners, her Chief Counsel, and her Administratative Assistant. She thanked the committee for the opportunity to testify on Long Term Care Transition, Managed Care, Medigrants, and Privatization (see Attachment 3.) Secretary Chronister said she and her staff would be available to the committee to discuss issues at any time.

The questions the committee asked were addressed by Secretary Chronister and her Commissioners. Questions ranged from budgeting various programs to electronic transfers (debit cards) and their feasibility. Questions about the privatization of food service in prisons were also addressed. Medicaid and the CARE program were also discussed.

Chairman Mayans thanked the Secretary and the Commissioners for coming and extended an invitation to come and talk to the committee again.

The meeting was adjourned at 2:50 p.m.

The next meeting is scheduled for January 11, 1996.

House Health & Human Services COMMITTEE GUEST LIST

DATE January 10, 1996

NAME	REPRESENTING
Tammara Capps	Bristol-Myers Squibb
myrle Myers	Johnson & Johnson
Joe Fujanic	KCA
[illegible] Ulrich	Resource Center for Indep. Living
Nancy Zogleman	Pfizer
[illegible]	SILCK
[illegible]	SRS
Teresa [illegible]	SRS
Rochelle Chronister	SRS
Connie Hubbell	SRS
Joyce Grissom	SRS
Ann Koci	SRS
Mary A. Hoover	SRS.
John Peterson	Ks Governmental Consulting
Rich Guthrie	Health Midwest
Jim Crumpacker	Governor's Office
Shelby Smith	KPMA
Jayne Edwards	Deputy Sec., KDOA
Kathy Kirk	OJA
Bill Carter	KDOA
Cheryl Dillard	HealthNet

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over →

Michelle Peterson	PhRMA
David Till	Seneca
Dawn Reid	KSNA
KEITH R LAUDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
DAZhn	KAHSA
Teresa S Hernandez	HIAP
Linda Byrne	KMHC
Monica Scaff	Ks. N.O.W.
Melissa Wangemann	Hein, Ebert & Weir
Denise Clemonds	NEK. area agency on aging
Meg Hanson	KMS
Laurie Ann Brown	KHA

HOUSE CONCURRENT RESOLUTION NO. ____

By

A CONCURRENT RESOLUTION urging all health insurers providing coverage for maternity benefits to provide their insureds who are eligible for obstetrical care with at least 72 hours of inpatient care following delivery of a newborn child.

WHEREAS, Some health insurers offer incentives for and others mandate early hospital discharges for mothers and their newborn children, a practice which, according to the centers for disease control and prevention, has decreased the median length of stay from 1970 to 1992 by 46% for vaginal deliveries and by 49% for caesarean deliveries; and

WHEREAS, Some insured mothers and their newborn children have been required to depart hospitals 24 hours after the delivery; and

WHEREAS, Length of stay may affect the recovery of the mother and the newborn's stabilization and screening tests, and cases have been reported of injury to and death of newborn children who left the hospital 24 hours after delivery; and

WHEREAS, The American college of obstetricians and gynecologists and the American academy of pediatrics developed guidelines for perinatal care which provide that when no complications are present, the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for caesarean birth, excluding the day of delivery; and

WHEREAS, Health insurers are licensed to do business to serve as a device to distribute risk of economic loss among Kansans so that each insured Kansan is better able to pay health care providers for proper treatment of one's health care needs, not for early hospital discharges driven primarily by the insurers financial considerations which cause the insured to be at-risk: Now, therefore,

Be it resolved by the House of Representatives of the State

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of Kansas, the Senate concurring therein: That all insurers providing health benefit plans in Kansas that provide coverage for maternity benefits are urged to provide their insureds who are eligible for obstetrical care with at least 72 hours of inpatient care following delivery of a newborn child and provide notice of this coverage to their insureds as soon as possible; and

Be it further resolved: That the commissioner of insurance shall notify all affected insurers of the provisions of this resolution; and

Be it further resolved: That the commissioner of insurance is directed to report to the legislature by February 1, 1997, any information the insurance department has regarding compliance by insurers with this resolution and any complaints the insurance department has received from insureds concerning early hospitalization discharges following obstetrical delivery; and

Be it further resolved: That the secretary of state be directed to send enrolled copies of this resolution to the state department of insurance and to the commissioner of insurance, Kathleen Sebelius, 420 S.W. 9th Street, Topeka, Kansas 66612-1678.

Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

House Committee on Health and Human Services
Testimony on Managed Care, Medigrants, Privatization and Long Term Care Transition

January 10, 1996

Chairman and Members of the Committee, thank you for the opportunity to testify today concerning Long Term Care Transition, Managed Care, Medigrants and Privatization.

Managed Care

After more than two and one-half years of planning, Medicaid managed care -- the state's primary Medicaid health reform initiative -- has been implemented in five counties with additional counties' implementation planned throughout the next year. The hard work of scores of consumers, physicians, pharmacists, nurses, ancillary providers, hospitals, state staff, and consumer advocates is coming to fruition as managed care comes on line.

SRS was mandated by the Kansas Legislature to implement Medicaid managed care programs statewide for the Aid to Families with Dependent Children (AFDC) and poverty level pregnant women and children populations by July 1, 1997. To meet this goal, SRS established a statewide implementation committee, as well as local community workgroups, to solicit input and recommendations from the community, medical providers and Medicaid beneficiaries and advocates. The enclosed Fact Sheets give the background and history of the managed care project.

With managed care, SRS is completely revamping the way medical services are provided to vulnerable Kansans. Under the new system, Medicaid consumers -- primarily women, children, and the disabled -- designate a primary care provider for their health care needs. The primary care provider supplies all preventive and primary medical services and refers patients to specialists when needed.

The goals of managed care are five-fold:

- increase access to medical care for the population served by Medicaid;
- improve the quality of medical services;
- contain cost increases;
- preserve individual rights and dignity; and
- communicate better with health care providers.

Three different managed care programs are either under way or planned for Medicaid consumers in Kansas. Two of these programs, HealthConnect and PrimeCare Kansas, are already on line in five counties: Ellis, Ness, Saline, Ottawa, and Wyandotte counties. By July 1997, 80 percent of the state's 200,000 Medicaid recipients will be part of the state's managed care program.

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- **HealthConnect**, already operating in Ellis, Ness, Saline, Ottawa, and Wyandotte counties, is a primary care case management program where consumers designate a primary care provider for all their health care needs. The primary care provider, which could be a doctor, an advanced registered nurse practitioner, or health care provider within a clinic, will supply all preventive and primary medical services and refer patients to specialists when necessary. With HealthConnect, health care providers annually pick a caseload size they want from the Medicaid population, whether it be ten or 1,800. Medicaid recipients choose from among those providers who have agreed to see a certain number of Medicaid recipients.

Current number of providers who have approved HealthConnect Contracts as of January 3, 1996

County	Number of Case Managers with Approved HealthConnect Contracts*	Total Number of HealthConnect Slots** Available	Number of Slots** Needed in County (as of 11/21/95)
Ellis	14	14,832	1,406
Ness	3	225	92
Saline	25	2,868	3,108
Ottawa	3	300	209
Wyandotte	114	97,955	18,326
Johnson	60	17,625	5,826
Leavenworth	16	9,300	2,899
Douglas	19	6,046	3,478
Shawnee	30	13,866	10,810
Sedgwick	140	59,833	32,413
Total	424	204,925	78,567

*(Some contracts have been returned to providers for additional information)
**Slot = an opening in a provider's practice reserved for a Medicaid beneficiary

- **PrimeCare Kansas** , already operating in Wyandotte county, is a managed care program using health maintenance organizations (HMOs) under contract with the state where consumers can choose to enroll in an HMO and will choose a primary care provider within

the HMO. The HMO is then responsible for acting as an insurance company and providing most of the Medicaid beneficiaries' care. PrimeCare Kansas is a capitated managed care program. A set monthly fee is paid in advance to HMOs to provide medical services.

- A third managed care program for Medicaid consumers, **Community Care of Kansas (CCK)**, is a research and demonstration program using a special non-profit provider organization under contract with the state. It will serve beneficiaries in Sedgwick, Finney, Bourbon and Montgomery counties. CCK is designed to demonstrate a community-wide approach to Medicaid managed care that will enhance the choice of health care providers. Mental Health is included in the benefit package. Under the demonstration project, beneficiaries will be guaranteed enrollment in CCK for a minimum of 6 months. Beneficiaries under age 6 who were formerly eligible for Medicaid and their families' income remains under 200% of the federal poverty level will remain enrolled in CCK until they reach the age of 6.

The collaboration between SRS staff, medical community representatives, and Medicaid consumers has been instrumental in the development of the new managed care programs. As the new managed care programs come on-line, there is bound to be an adjustment period for consumers and providers. Toll-free numbers have been established by all HMOs to field consumer and provider inquiries. SRS has also established toll-free hot lines for consumers and providers to ask questions and to raise their concerns.

MediGrants

The Reconciliation Bill (HR 2491) included a new health care program for low income individuals, persons with disabilities, and the elderly called "MediGrant". It replaces the current Medicaid program under Title XIX, proposes an entitlement to states and operates as a shared state and federal program. The President vetoed HR 2491 and submitted his own proposal which maintains individual entitlements, establishes a per capita cap, increases flexibility for states and reduces and retargets disproportionate share hospital spending. Both proposals mandate specific groups of persons to be served through the Medicaid program. The Reconciliation Bill mandates immunizations and family planning services only while the President's bill maintains the existing mandated services.

The future of the federal Medicaid program is, of course, part of the negotiations between the President and Congress. Discussion is very high level with the key issues being: per capita cap versus an aggregate cap, mandatory groups, and the level of federal participation. It is difficult to predict the outcome of the debate on federal health care entitlements and thus we are unable to define which statutes may need to be changed.

Privatization

SRS is pursuing privatization on both operational and service levels seeking improved services, flexibility, and efficiency. Privatization may involve an entire operation or a subset. Following

are the areas where privatization is currently being pursued and implemented, as well as those areas being explored.

Children and Family Services

- Family Preservation: involves five regions statewide; implemented July 1, 1996; a Request For Proposal (RFP) has been issued.
- Adoption: one region statewide, implemented August 1, 1996.
- Foster/Group Care: five regions statewide; implemented September 1, 1996.

Income Maintenance and Employment Preparation Services

- Kanwork Training Agreements: initiated January 1, 1996; $750,000 is available for five training components for January to June; services include client job assessments, job search, job development and job placement.
- Child Care: in the discussion and information-gathering stages.
- Electronic transfer of AFDC and Food Stamp Benefits; contract awarded to Deluxe Data Systems of Milwaukee, Wisconsin; implementation phased-in over nine months starting July 1, 1996.

Rehabilitation Services

- Kansas Industries for the Blind: implemented July 1, 1996; RFP to be issued in early February.
- Kansas Quality Assurance Screening: a screening program for certification of sign language interpreters operated by the Kansas Commission for the Deaf and Hard of Hearing; implemented July 1, 1996.

Child Support Enforcement

- Foster Care Debt Recovery Effort: RFP will be issued after February 1, 1996.
- Enforcement of child support enforcement orders: RFP will be issued after February 1, 1996.

Mental Health and Developmental Disabilities

- Medical Services at Topeka State Hospital: implemented October 1, 1995; operation of Ancillary Services (laboratory, X-ray, pharmacy and others).
- Medical Services at Osawatomie State Hospital: the hospital is discussing a similar arrangement with the University of Kansas Medical Center.
- Community Developmental Disabilities Organization staff training: to train CDDO staff and organize the annual Kansas Conference on Developmental Disabilities; estimated FY 96 expenditures total $118,000.
- Food Service: in collaboration with the Department of Corrections, an RFP was issued the week of January 2, food service operations in state hospitals, youth centers and correctional facilities.

Adult and Medical Services

- Pharmacy Rate Setting: ongoing
- Hospital Utilization Review: ongoing
- Hospital Rate Setting: ongoing
- Third Party Liability Collection: ongoing
- Capitated Managed Care: over time

- Contracts with Information Technology Vendors: ongoing
- Direct Delivery Services in Home and Community Based Services: completion by July 1, 1997
- Case Management: completion by July 1, 1997

Long Term Care Programs Transition Plan to Kansas Department on Aging

The Department of Social and Rehabilitation Services in conjunction with the Kansas Department On Aging have been busy formulating a transition plan and conducting public hearings. All of which have been accomplished with the help of provider and consumer representatives.

Secretary of Aging, Thelma Hunter-Gordon, will present a more detailed testimony to the committee later this week.

Realignment - Living Independence For Everyone (LIFE)

A copy of the fact sheet and flow chart on the proposal of refinancing Medicaid long term care programs is attached. LIFE encourages living independence to the greatest extent possible in the least restrictive environment by establishing thresholds to determine the services needed for an individual seeking assistance. LIFE includes funding for services in assisted living and residential care through the HCBS/NF Waiver program to promote the diversification of nursing facilities to provide needed community services. Thus, LIFE provides for an "in-between" care service for those who do not require admission to a nursing home. LIFE creates more flexibility in Medicaid financial eligibility rules to allow consumers more choices in housing options yet approves service options based on individual need regardless of housing choice. Finally, LIFE enhances effective case management using uniform assessments, reviews and local control which creates a statewide single point of entry system.

The implementation of LIFE has been a process of team work with providers, consumers, and other federal and state governmental agencies. An executive task force and subcommittees continue to meet to establish the programs goals and objectives. Level of care thresholds have been established using the CARE (Client Assessment, Referral and Evaluation) and the MDS+ (Minimum Data Set) assessments. Services to be paid for have been defined by a subcommittee and reimbursement for those services is being established. Discharge status guidelines are being developed for both the Home and Community Based Services Program and the Nursing Facility Program. The waiver amendment is being drafted to the Health Care Financing Administration in order to receive federal approval for the program. The agency will begin an education process of the program for consumers and providers after receiving approval. Levels of care will then be determined with the CARE and MDS+ assessments. We are targeting for a July 1, 1996 implementation date.

SRS Medicaid Managed Care — Fact Sheet #1

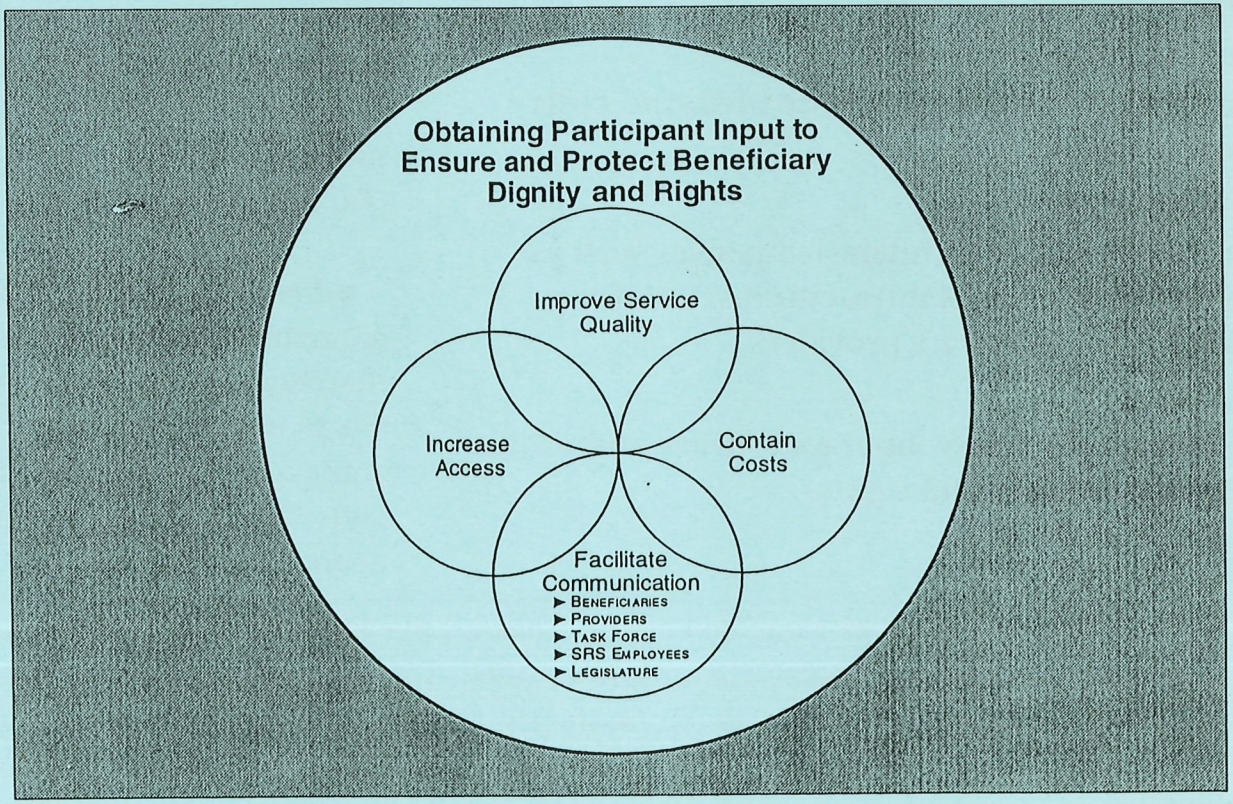
Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

SRS Medicaid Managed Care Mission Statement

SRS seeks to improve the quality, access and cost effectiveness of health care provided to eligible persons through managed health care solutions, while recognizing and preserving individuals' rights and dignity.

What is Managed Care?

***Managed care** is a form of health plan (i.e., fully prepaid, partially prepaid, or case management with post-paid services) providing health care services to patients using a single doctor or organization to emphasize preventive health care and a reduction in unnecessary care and high costs.*



Goals of Kansas Managed Care

- Improve service quality
- Increase access
- Contain cost increases
- Communicate with interested parties
- Ensure and protect benificiaries dignity and rights

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SRS MEDICAID MANAGED CARE
FACT SHEET #1

GOALS OF THE SRS MEDICAID MANAGED CARE PROJECT

GOAL 1

To improve the quality of services provided to the Medicaid population.

GOAL 2

To improve Medicaid beneficiaries' access to health care through managed care.

GOAL 3

To contain the increases in state Medicaid costs through managed care.

GOAL 4

To communicate with interested parties such as beneficiaries, the Legislature, citizens, task force members and health care providers.

GOAL 5

To receive beneficiary input and ensure and protect beneficiaries dignity and rights.

MANAGED CARE IN KANSAS

The two types of managed care that will be established in the Kansas Medicaid program are:

- **Kansas Prepayment for All Health Care Services.** This type of fully capitated care works best in urban areas with several existing Health Maintenance Organizations (HMOs). HMOs will contract with the State in the PrimeCare Kansas project. A similar model is being proposed in Wichita with the Community Care of Kansas (CCK) project.

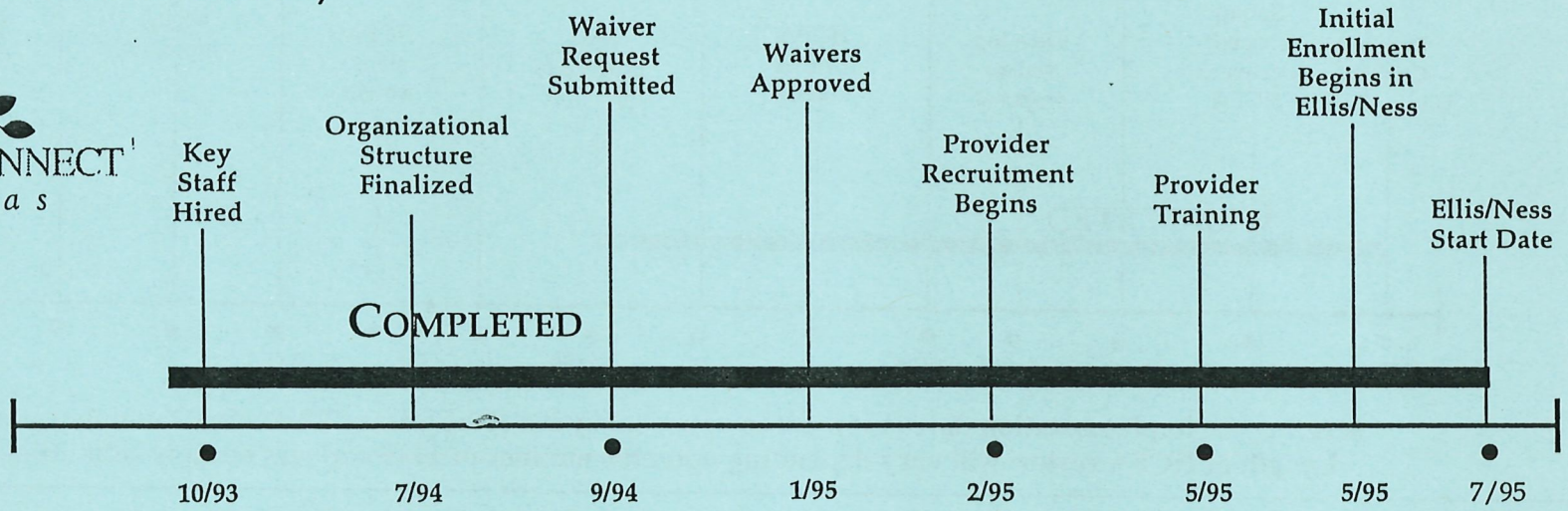
- **Primary Care Case Management (PCCM).** Providers are reimbursed on a fee-for-service basis in addition to a monthly case management fee. This type of managed care works best in rural and urban areas with no other managed care plans or for high cost patients. Kansas Medicaid presently has a PCCM program, called HealthConnect, in 7 counties.

SRS was mandated by the Kansas Legislature to implement managed care programs statewide by July 1, 1997. To meet this goal, the Secretary of SRS established a statewide Implementation Committee, as well as local community workgroups, to solicit input and recommendations from the community, medical próviders and Medicaid beneficiaries and advocates.

SRS Medicaid Managed Care — Fact Sheet #2

Primary Care Case Management / HealthConnect (Ellis/Ness, Wyandotte, Johnson, Douglas, Leavenworth, Shawnee, Saline and Sedgwick counties)

HEALTHCONNECT Kansas



*Remaining counties phased in by 7/1/97.

*County Timeline

	Ottawa/ Saline	Wyandotte	Leavenworth/ Johnson	Douglas/ Shawnee	Sedgwick
Enrollment Date	September	September	December	Jan./1996	March
Start Date	November	December	Feb./1996	March	May
Status	Completed	Completed	In progress		

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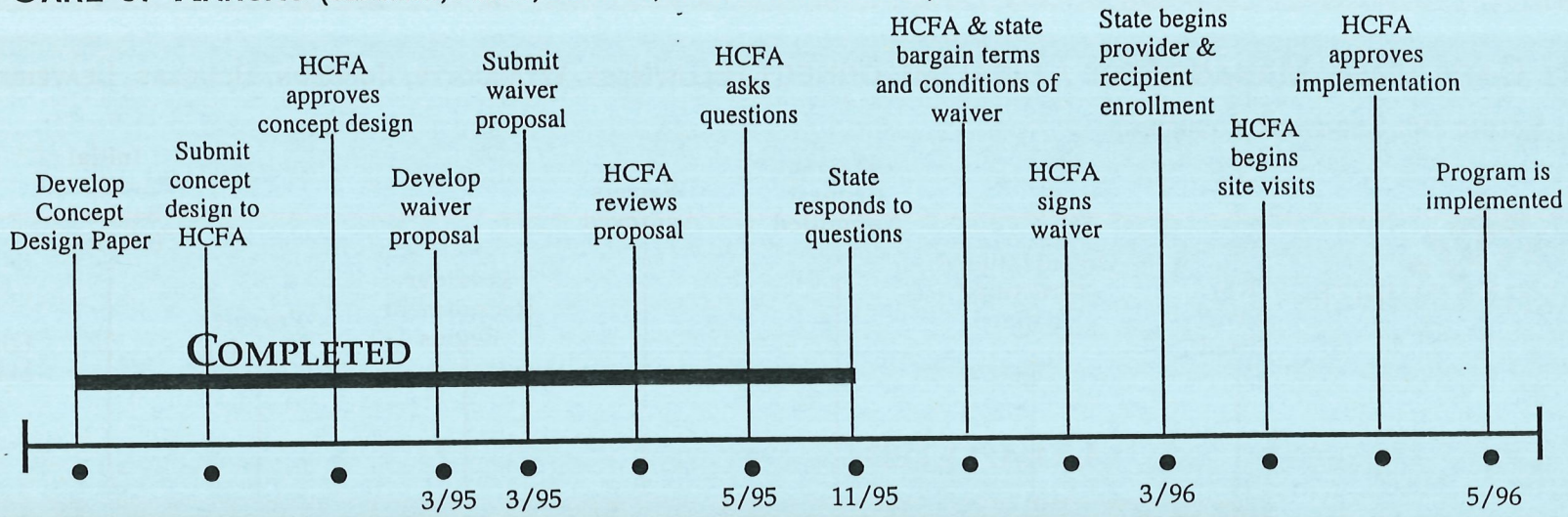
SRS Medicaid Managed Care
Fact Sheet #2

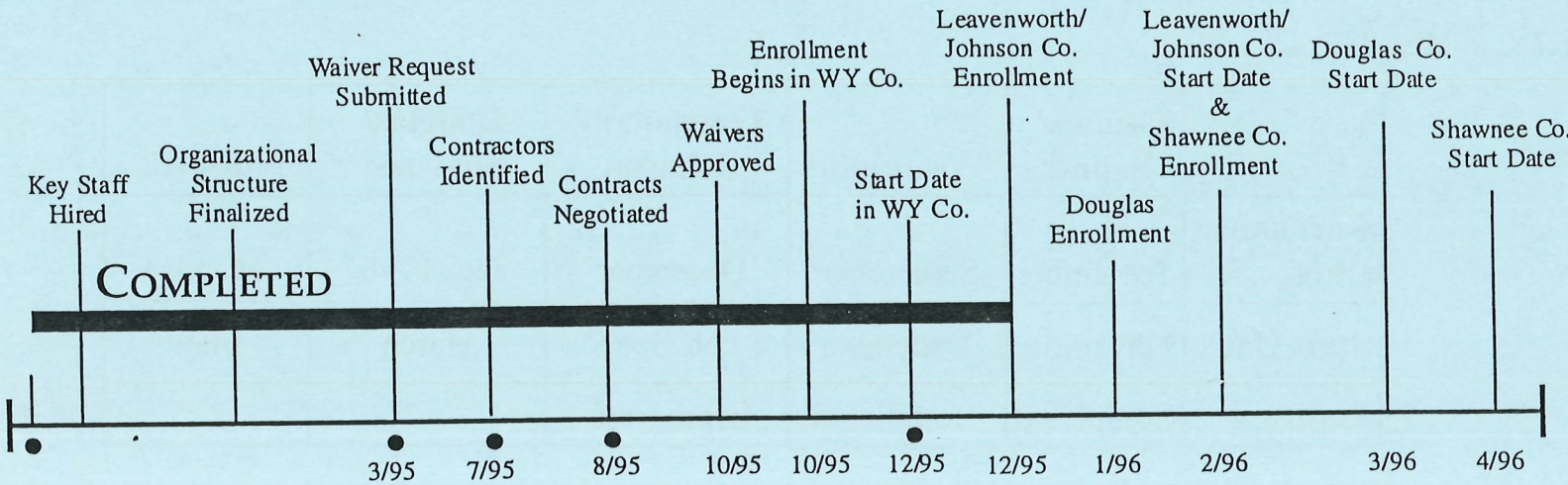
Community Care of Kansas (Sedgwick, Finney, Bourbon, Montgomery counties)



Meeting the implementation date is subject to approval by the Health Care Financing Administration. Length of HCFA review will vary depending upon the number of 1115 waivers already submitted.

HMO / PrimeCare Kansas (Wyandotte, Johnson, Douglas, Leavenworth, Shawnee counties)

PRIMECARE
Kansas



SRS Medicaid Managed Care — Fact Sheet #3

Plan for the Statewide Phase-in for Medicaid Managed Care

Prog. Start Date	Program	Populations	Counties
1984	PCN (now HealthConnect)	AFDC/PLE/ SSI/GA	Saline, Sedgwick, Douglas, Wyandotte, Leavenworth, Johnson, Shawnee
July 1995	HealthConnect	AFDC/PLE/ SSI/GA	Ellis, Ness
November 1995	HealthConnect	AFDC/PLE/ SSI/GA	Ottawa
December 1995	PrimeCare Kansas (HMO)	AFDC/PLE	Wyandotte
February 1996	PrimeCare Kansas (HMO)	AFDC/PLE	Johnson, Leavenworth
March 1996	PrimeCare Kansas (HMO)	AFDC/PLE	Douglas
April 1996	PrimeCare Kansas (HMO)	AFDC/PLE	Shawnee
May 1996	Community Care of Kansas	AFDC/PLE	Sedgwick
August 1996	PrimeCare Kansas (HMO) HealthConnect	AFDC/PLE/ SSI/GA	Atchison, Miami, Franklin
September 1996	Community Care of Kansas	AFDC/PLE	Bourbon, Montgomery

This chart is a skeleton plan to implement the statewide Medicaid managed care program.

As experience is gained through the pilot projects and federal mandates for health care change, the timelines may be adjusted.

Key to Populations:
AFDC: Aid to Families with Dependent Children
PLE: Poverty Level Eligible
SSI: Supplemental Security Income
GA: General Assistance

***Remaining counties phased-in by 7/1/97.**

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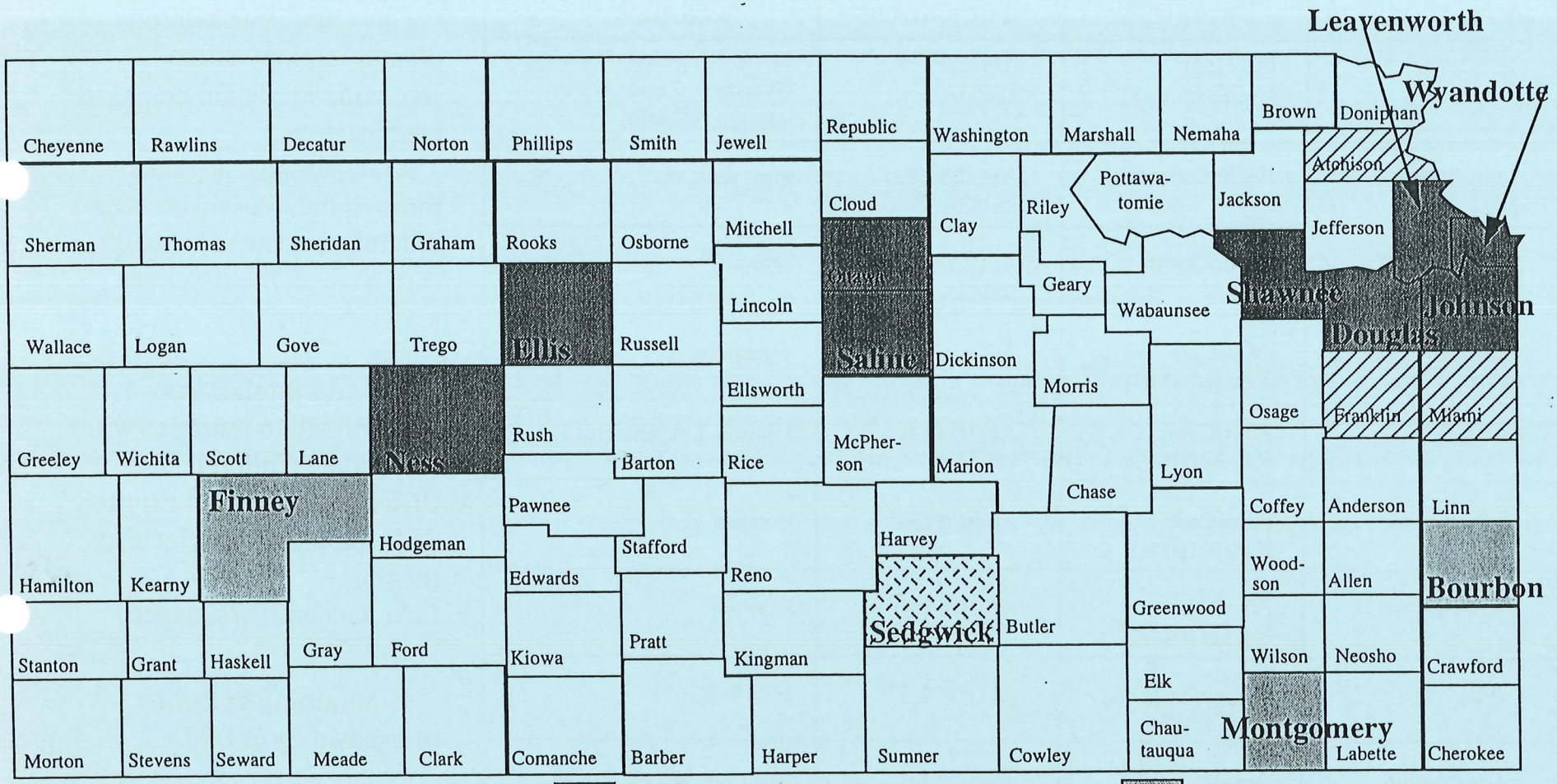
SRS MEDICAID MANAGED CARE

FACT SHEET #3



Future Managed Care County

Current Managed Care County

1115 Waiver County

Combination County: 1115 Waiver/Current

SRS MEDICAID MANAGED CARE — FACT SHEET #4

PROGRAM INTEGRITY AND QUALITY MANAGEMENT

When establishing a quality assurance plan for Kansas Medicaid Managed Care, SRS must follow federal guidelines and the framework for Quality Assurance established by the Health Care Financing Administration (HCFA). In 1991, HCFA began to develop a recommended framework for a Health Care Quality Improvement System for state Medicaid managed care programs. HCFA recommends the following five elements be included in that framework:

- **Quality Assurance Program** - HCFA requires the managed care organization have an internal quality assurance program which contains clear and detailed standards as set forth by the State and is effective and reliable in monitoring and evaluating service provision and also is responsive to the need for corrective action to effect improvement in identified problem areas.

- **State Monitoring** - HCFA requires the State to assess to what extent the QAP meets the State-specified standards, to have annual independent, external review of service quality (HMOs) and to have annual medical audits of pre-paid health plans.

- **Federal Oversight** - HCFA requires itself to monitor the State's oversight of Health Maintenance Organizations and Primary Care Case Managers for the acceptability of the Quality Assurance Program and the performance/outcome of annual reviews/audits of Health Maintenance Organizations and Primary Care Physicians.

- **Recipient Involvement in HCQIS** - HCFA requires states and Health Maintenance Organizations and Prepaid Health Plans, such as PrimeCare Kansas and Community Care of Kansas, to have an enrollee grievance process provided within the managed care organization and Medicaid agency.

- **Monitoring and Evaluating the HCQIS** - HCFA recommends that each state monitor, evaluate and revise the state's Health Care Quality Improvement System on a periodic and regular basis.

SRS MEDICAID MANAGED CARE
FACT SHEET #4

CONSUMER ENROLLMENT IN MEDICAID MANAGED CARE

The consumer enrollment process will educate and enroll consumers in a timely manner to facilitate assignment to a case manager as quickly as possible. Individual counseling can be targeted at consumers identified as having problems accessing care properly.

Under the new enrollment system, consumers will be given a choice of managed care providers and plans. After a set amount of time, if the client has not chosen a managed care option, they will be assigned to a managed care plan/provider on a pre-determined, rotating basis.

Consumers will only be allowed to change managed care providers if they have good cause to do so. A semi-annual open enrollment period will be offered so that enrollees may change plans without cause.

Five regional coordinators will be based in SRS area offices and supervised by Central Office during managed care implementation. The coordinators will have the following responsibilities:

- Coordinate consumer enrollment in the PCCM program and the capitated managed care program with the outside contractor and the Commission of Adult and Medical Services.
- Develop and conduct consumer workshops to offer education and training to consumers on the philosophy of managed care and the enrollment process.
- Offer a personal contact for consumers needing further explanation of the system and enrollment procedures.
- Educate and train local office staff on the managed care program and the enrollment process.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Division of Adult and Medical Services
LIVING INDEPENDENCE FOR EVERYONE (LIFE) FACT SHEET
January 4, 1996

SRS in conjunction with more than 80 representatives from consumer, provider, advocacy associations and other state and local governmental agencies have been meeting since July, 1995 to realign and refinance Medicaid LTC programs. The outcome is LIFE and will be achieved through comprehensive amendments to the HCBS/NF waiver and state plan. The waiver amendments require Health Care Financing Administration (HCFA) approval. Implementation is targeted to begin in July, 1996.

Goals
- Provide LTC services to consumers in the least restrictive setting which meets needs and is cost-effective
- Separate service reimbursement from consumer's housing choice
- Expand opportunities for NF's to provide HCBS services
- Create a single system of case management for frail elders
- Provide a funding source for services in Assisted Living and Residential Care

Eligibility Group
- Individuals age 65 and older
- Meet Medicaid LTC Threshold criteria
- Meet Medicaid Financial Eligibility criteria

Funding and Reimbursement
- Only existing resources will be used
- Reimbursement rates for services are not yet established
- NF reimbursement rate structure is not being altered

Service Definition
- Consolidation of LTC services into eight categories:
  - Targeted Case Management for Frail Elders
  - Adult Day Care
  - Sleep Cycle Support
  - Personal Emergency Response
  - Health Care Attendant
  - Wellness Monitoring
  - Respite Care
  - Nursing Facility Services

LTC Threshold Criteria
- Includes Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), IADL Proxies, and Risk Factors
- Weights level of impairment
- Both lower and upper thresholds are monitored for care planning
- NF services are only available if upper threshold criteria are met
- Cost cap exceptions for HCBS services will be limited

Assessment Tools
- Uniform Assessment Tool (UAI) establishes lower LTC Threshold and monitors continued eligibility for all services except NF
  NOTE: First two pages of the UAI are identical to the CARE assessment and will not be a duplicate assessment
- MDS+ monitors continued eligibility for NF services

Targeted Case Management for the Frail Elderly
- Medicaid State Plan Service
- Scope of Service includes:
  - Assessment/Reassessment Plan of Care Development
  - Monitoring/Quality Assurance
  - Resource Development
  - Gatekeeping
  - Documentation
  - Advocacy
- Requires 4 yr. college degree or Registered Professional Nurse with 1 yr. experience in human services.*
- Must be employees of or contractors with AAA's and shall not be providers of other direct services.**
- Service plans require approval by Medicaid Regional Authority.

Other Service Providers
- All LTC services will be privatized
- NF, Assisted Living and other residential care homes, HHA, and other individuals or agencies qualified to provide services
- Includes option for Consumer Directed Attendant Care

Quality Assurance
- Independent audits
- Case Management
- Annual reviews by fiscal agent
- Oversight by SRS
- Consumer satisfaction surveys

c:chart4LIFE

* Individuals with at least twelve months experience on or before January 1, 1996 as a SRS LTC Case Manager in good standing shall be considered as having met education and work related requirements.

** Targeted Case Management agencies may provide other direct services if there are no other available providers in the region and prior authoriza from the Medicaid authority is approved.

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