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PROGRAM INSTRUCTION

EOEA-PI-93-70
REF: EOEA-PI-93-46

TO: Home Care Corporations
Area Agencies on Aging

FROM: Franklin P. Ollivierre

DATE: December 20, 1993

RE: Implementation of CICLE: Primary Care Component

Home Care Corporation (HCC) allocations for FY94 included funding to provide intensive case management services to clients who need assistance with primary care access. This funding was included in each HCC's "base" and "uniform intake" case management rates as of July 1, 1993. Performance outcomes have been identified in the FY94 contracts regarding client linkages to primary care.

Implementation of CICLE was originally intended for August, but was postponed in recognition of the complexities of the initiative. Through the use of a workgroup consisting of HCC representatives, the procedures and expectations of the primary care component of CICLE were reviewed and refined.

On January 1, 1994, the primary care component of the Comprehensive Initiative for Community Linkages (CICLE) will be implemented. The purpose of this Program Instruction is to provide clarification to EOEA-PI-93-46; the following information takes precedence over the previous instruction.

As you know, the purpose of the primary care component of the CICLE Initiative is to ensure that clients understand the importance of establishing and maintaining an appropriate use of primary health care. The following information will assist HCCs with implementation of the primary care component of CICLE:

I. Identifying/Targeting Clients

Case material for all current and new clients shall be reviewed to determine the presence and/or utilization of a primary source of health care.

Targeted clients are defined as:

* a client without a primary source of health care; or

* a client who does not appropriately utilize a primary source of health care, i.e. repeated emergency room visits, multiple specialist visits without any primary source of health care, multiple medications prescribed by several physicians, lack of any recent contact with listed primary source of health care, etc.

Note: A primary source of health care includes all providers who manage/coordinate a client's health care, i.e. physician, nurse practitioner, Adult Day Health program, clinic, certified home health agency, etc. The chosen provider, if not a physician, must function under physician orders.

Linkages are defined as:

* HCC intervention which results in the linkage of a targeted client to a primary source of health care; or

* HCC intervention which results in appropriate utilization of a primary source of health care by a targeted client.

II. Home Care Interventions

Several types of intensive intervention by the HCC may be appropriate on behalf of targeted clients. The HCC shall provide the following assistance to targeted clients when necessary:

* Information about primary health care options in the client's geographic area

* Assistance with problems relating to health care delivery

* Discussion with client/family about the importance of maintaining regular contact with a primary source of health care

* Assistance in scheduling appointments/home visits

* Background information to the chosen primary source of health care about the client situation

* Assistance with appropriate follow-up/referrals

* Authorization of transportation necessary to ensure access to primary source of health care

* Authorization of coordination with other services determined necessary through primary care contacts, i.e. home health benefits

* Participation in attendance at medical visits (with client's consent)

III. Standards of Practice

In addition to the interventions conducted on behalf of targeted clients, the following activities shall be conducted by HCCs on behalf of all clients:

1. A process shall be in place to ensure that client case material will be reviewed to determine the presence and/or utilization of a primary source of health care.

2. A resource system shall be in place at the HCC which includes all geographically based primary care resources. This information shall include all Adult Day Health providers and all Certified Home Health Agencies. It shall also include physicians, nurse practitioners, and clinics such that the client has a wide array of choice when selecting an appropriate provider. Additional information regarding relevant details (i.e. availability of home visits, handicapped accessibility, etc.) will be provided to the client as needed.

3. Current information on Medicare coverage for primary and preventive health care services shall be made available to clients (an example of material which provides this information is attached).

IV. Documentation/Performance Outcomes

HCCs will be required to submit the following information to Elder Affairs regarding their efforts for the CICLE initiative:

1. # of linkages established

2. # of clients receiving intervention efforts although linkage has not been established

We recognize that some HCCs have established primary care

linkages prior to the January 1st implementation of CICLE. Consequently, HCCs will submit status reports on CICLE activities which took place during the first six months of the fiscal year by February 15, 1994. As of January 1, 1994, CICLE activities will be reported quarterly; the first quarterly report will be submitted by April 30, 1994. This information, which includes case identification numbers, will be submitted on the attached form to Judy Cranney at Elder Affairs.

HCCs will document in the case record (i.e. Problem List) if a client is targeted for CICLE intervention. The reason(s) for CICLE targeting, all intervention efforts, and any subsequent linkages must also be documented in the client case file.

If you have any questions regarding this Program Instruction, please contact Judy Cranney at 727-7750 x336.

FPO:LR

CICLE - PRIMARY CARE COMPONENT
REPORT FORM

Home Care Corporation:_____
Date:_____
Completed by:_____

I. Number of Linkages: _____

Client Identification Numbers:

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II. Number of clients receiving intervention efforts although linkage has not been established: _____

Client Identification Numbers:

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MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES FOR 1993

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. (Medicare payments based on benefit periods, see page 14).	First 60 days	All but $676	$676
	61st to 90th day	All but $169 a day	$169 a day
	91st to 150th day[1]	All but $338 a day	$338 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days and enter a Medicare-approved facility generally within 30 days after hospital discharge.[2] (Medicare payments based on benefit periods, see page 14.)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $84.50 a day	$84.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent care for as long as you meet Medicare conditions.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	If you elect the hospice option and as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Unlimited if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.[3]

1993 Part A monthly premium: None for most beneficiaries.
$221 if you must buy Part A (Premium may be higher if you enroll late).

[1] This 60-reserve-days benefit may be used only once in a lifetime
[2] Neither Medicare nor private Medigap insurance will pay for most nursing home care
[3] To the extent the blood deductible is met under Part B of Medicare during the calendar year, it does not have to be met under Part A.

E ted from:
1993 Medicare Handbook
Department of Health and Human Services

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES FOR 1993

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, ambulance, diagnostic tests, and more.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $100 deductible).	$100 deductible,[1] plus 20% of approved amount and limited charges above approved amount.[2]
CLINICAL LABORATORY SERVICES Blood tests, urinalyses, and more.	Unlimited if medically necessary.	100% of approved amount.	Nothing for services.
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent skilled care for as long as you meet conditions for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of illness or injury.	Unlimited if medically necessary.	80% of approved amount (after $100 deductible).	$100 deductible, plus 20% of billed charges.
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible).[3]
1993 Part B monthly premium: $36.60 (Premium may be higher if you enroll late).			

[1] Once you have had $100 of expenses for covered services in 1993, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

[2] See 'When Your Doctor Does Not Accept Assignment,'

[3] To the extent the blood deductible is met under Part A of Medicare during the calendar year, it does not have to be met under Part B.

Exc ed from:
The 1993 Medicare Handbook : Department of Health and Human Services