Notice of Instruction

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Notice of Instruction Number:

#012109-Updated ARC Waitlist Management and SGR Care Plan Review Procedures-KP

TO: All Lead Agencies/PSA 6

FROM: Katie Parkinson, Director of Program Management (Extension 5574)

DATE: January 21, 2009

SUBJECT: Updated ARC Waitlist Management and Referral Procedures

cc: Program Managers

This Notice of Instruction is to provide your agency with updated Aging Resource Center (ARC) Waitlist Management and Referral Procedures.

The attached updated procedures **#Client001** and **#Budget003** outlines the steps that have been established by WCFAAA for prioritization and enrollment of consumers through Waitlist Enrollment Procedures. This revision includes the following update:

#Client001

- Updates procedure to allow State General Revenue funded care planned services that do not exceed risk level targeted values to be implemented prior to WCFAAA approval.

#Budget003

- Establishes the authority for Lead Agencies to implement care planned services for State General Revenue funded consumers that do not exceed risk level targeted values prior to approval by WCFAAA.

- Updates the chart for PSA target values by risk level.

- Clarifies that once WCFAAA approves a level of care planned services further approval is not required unless units of service are to be increased or new services added.

Thank you for your continued commitment to Florida's elders. Should you require additional information, please contact Earl Smith, WCFAAA Medicaid Waiver Specialist/ARC Enrollment Manager, 813-676-5576 or smithe@elderaffairs.org.

Attachment-
WCFAAA ARC Waitlist Management and Referral Procedures **PUOP #Client001**
WCFAAA ARC Waitlist Management and Referral Procedures **PUOP #Budget003**

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PUOP# Client001 Revision: 4 **Prepared By: KP**
Effective Date: 12/18/2008 **Approved By: GDS**

Title: **Aging Resource Center (ARC) Waitlist Management and Referral Procedures**

Policy: The ARC is responsible for ensuring that services for CARES Unit and Community Referral designated frail elders are initiated promptly to consumers with greatest need for services.

Purpose: To outline the procedure used to ensure consumers are screened, assessed and prioritized on the appropriate waiting list. This procedure outlines the steps involved in waitlist management in order to ensure consumers are screened or assessed requesting services are prioritized for service enrollment.

Scope: This procedure outlines the steps involved in waitlist management to ensure consumers requesting services are prioritized for enrollment and in accordance with the following Notices of Instruction (NOI):

- WCFAAA NOI #040904-IMM RSK-SGR-GS and the correlating Department of Elderly Affairs (DOEA) NOI #102403-1-I-PE and Policy Clarification #011404-1-PC-PE ;
- WCFAAA NOI #061907-CIRTS-CARES Referral-KP and the correlating DOEA NOI #060407-1-I-SWCBS; and
- WCFAAA NOI #051408-Updated ARC Waitlist Management and Referral Procedures-KP and the correlating DOEA NOI #041708-1-I-SWCBS.

Responsibilities: The Intake & Screening Specialists are responsible for ensuring frail elders contacting the ARC are assessed and prioritized for services in a timely manner.

The ARC Enrollment Manager is responsible for ensuring frail elders on the waitlist are released to receive services based on the greatest need and in a timely manner.

Procedure:

❖ **Waitlist Management** (established by WCFAAA)

1. Anyone screened or assessed and requesting services which are not available must be put on a waiting list.

2. The Intake and Screening Specialist is responsible for contacting the CARES Unit within three (3) days of receipt of any Imminent Risk referral. The CARES Unit will need to be notified if funding is unavailable and the consumer will be placed on the waitlist. Funding allowed, Imminent Risk referrals must be seen by lead agency case manager within three (3) business days.

3. The Intake and Screening Specialist is responsible for updating CIRTS within five (5) days to acknowledge referrals made by the CARES Unit. The “Date Received” field in the CARES Referral Information screen is to be updated along with the imminent risk designation (N=not imminent risk; Y=imminent risk).

4. In order to maintain the waitlist, consumers must be reviewed at least every six (6)

months with priority rank 3, 4, 5 or 6 and at least annually for consumers with priority rank 1 or 2 by the Intake and Screening Specialist, with the exception of Imminent Risk referrals (as detailed below).

5. If unable to locate by telephone, those clients/caregivers/representatives are sent a "10-Day Letter" notifying them of the ARC's attempt to update client waitlist information. The letter is sent to the last known address and states that their application will be terminated in 10 days if a response is not received.

6. Imminent Risk referrals placed on the Assessed Prioritized Client List (APCL) must be reviewed every month by a certified case manger to determine if there has been a change in the situation, as required by the DOEA Policy Clarification-NOI 102403-1-I-PE. This process is to be repeated until the client is either released from the waitlist to the lead agency for pick up or has been terminated from the waiting list.

7. The Imminent Risk client's whose condition has improved or there has been a change in the support system making the client no longer imminent risk, will have their assessment updated to indicate the client is no longer at Imminent Risk.

8. The Lead Agency may add a waitlist enrollment screen into CIRTS for an actively served consumer in need of enrollment in an additional program(s) based on the complete and current 701B Assessment (i.e. CCE Active requesting MW services).

   - For example: An active CCE consumer requesting Medicaid Waiver services may be enrolled by their lead agency as MW APCL based on the current 701B completed by the case manager. (Clients may not be enrolled as MW Applicant APPL without a WCFAAA Funding Request approval.)

   - Consumers receiving case management and dually enrolled (CIRTS Enrollment Screen program status codes set to "APCL" and "ACTV") in the following programs: ADI, CCE, HCE, LSP, OAA and ADA/ALE Medicaid Waivers will be assessed by the case manager annually using Form 701B.

     - Case managers have the responsibility to conduct semi-annual care plan reviews and annual reassessments.

     - If there is a significant change between annual assessments, an "update" type assessment will reflect a new priority ranking score on the APCL.

9. Funding allowed, the ARC Enrollment Manager will release a specified amount of either ADI/HCE/ALW/CCE/MW program waitlist applicants to be assessed for pick up by a case manager;

10. The ARC Enrollment Manager will then run a report by specific program and priority score of these waitlist clients, using CARES/Lead Agency Imminent Risk referrals first, as they have priority status and must be released first.

11. The ARC Enrollment Manger will release clients according to the following priority order:

    - Imminent Risk, Aging Out, Community Referrals by Priority Score, in descending order, are referred to case management for assessment.

12. The ARC Enrollment Manager will forward authorized consumers to the lead agency for enrollment.

13. The ARC Enrollment Manager will update CIRTS enrollment from APCL to APPL to indicate consumer has been authorized and released for pickup by the lead agency.

14. The lead agency is responsible for updating CIRTS with the appropriate Active or Termination program enrollment codes once the client has been assessed for services by case manager using Form 701B.

❖ **Imminent Risk Referrals authorized to receive Case Management Services**

1. The Case Manager will have **<u>3 business days</u>** from date that the Imminent Risk referral is received from the ARC to complete a 701B as required in the WCFAAA NOI 040904-IMM-SGR-GS and correlating DOEA NOI #041404-1-PC-PE..

2. The Case Manager will contact the CARES Unit to notify the CARES worker that the consumer has been assessed and notified of any services that will be provided. If services will not be provided to consumer, the Case Manager will provide the CARES Unit with an explanation.

3. The Case Manager will complete the care plan and service authorizations, if needed, at the time of the assessment (701B).

4. The case manager will forward the Care Plan Staffing Request to the ARC Enrollment Manager within **<u>five (5) business days</u>** of assessment and service implementation for review and approval.

    - NOTE: Services to CARES Imminent Risk consumers may be provided prior to the care plan staffing request approval by WCFAAA, due to the at risk nature of this type of referral. It is expected that needed services will be put into place immediately.

5. The ARC Enrollment Manager will review Care Plan Staffing Request and respond to the case manager's request within **<u>five (5) business days</u>** of receipt.

6. The lead agency will update the Client Information Registration Tracking System (CIRTS) to reflect the client's active status, including assessment and care plan information within seven (**<u>7) business days</u>** of completion of the assessment.

7. CARES Imminent Risk Exception Report: The ARC Enrollment Manager will forward a CARES Imminent Risk Exception Report at least monthly to the Lead Agency identifying each Imminent Risk client who was authorized to receive services, but is not yet showing active in CIRTS. The Lead Agency is required to provide a status update for each client, including service implementation information. The ARC Enrollment Manager will review the responses and follow-up as required.

❖ **All Other Referrals**

1. For all referrals, except for a referral to the Assisted Living Medicaid Waiver program, the 701B and the care plan staffing request must be completed within **<u>seven (7) business days</u>** of the date the referral was released from WCFAAA.

2. For a referral to the Assisted Living Medicaid Waiver program, the 701B and the care plan staffing request must be completed within **ten (10) business days** from the date that the referral has been authorized for funding by WCFAAA.

3. Care planned services that exceed the applicable risk level targeted values must be reviewed and approved by the ARC Enrollment manager prior to implementation.

   - For State General Revenue Programs only, care planned services that are at or below the risk level targeted values may be implemented prior to approval by the ARC Enrollment Manager.

   - Additional services exceeding the PSA target values for State General Revenue consumers are not to be implemented until final approval by WCFAAA.

   - All Medwaiver care planned services must be reviewed and approved by the ARC Enrollment Manager/Medicaid Waiver Specialist prior to implementation.

   - The care plan staffing request must be submitted to the ARC Enrollment Manger for review within **five (5) business days** of the date of the assessment.

4. The client's services must be implemented within **five (5) business days** of the Care Plan Staffing Review authorization.

5. CIRTS must reflect the client's active status including assessment and care plan information within **seven (7) business days** of a completion of the assessment (701B).

❖ Returning Authorized Consumers to the ARC Waiting List

1. Consumers screened using Form 701A and receiving a priority ranking score of 3, 4, or 5 with a CIRTS Enrollment Screen program status code set to "APPL", who are subsequently assessed using Form 701B and who receive a new priority ranking score of 1 or 2 cannot be enrolled.

   - This will allow for prioritization of other consumers on the APCL with priority ranking scores of 3, 4, or 5.

2. The Lead Agency will terminate the APPL status in CIRTS, and notify the ARC Enrollment Manager that the client will not be enrolled along with the reason.

3. The Lead Agency is responsible for updating the CIRTS Enrollment Screen. CIRTS is to be updated with the following enrollment code to terminate a consumer from APPL and open an APCL enrollment line; or closing the APPL for clients who choose not to wait for services:

   - TPCL (Terminated APPL moved back to APCL) for client who desire to continue to wait for services although their priority score is too low to be picked up.

- Lead Agencies are to open an APCL line up for the client to allow for continued waitlist maintenance of the consumer's assessment.

- TPBC (Terminated APPL by Client) for clients who do not wish to continue to wait for services and request termination.

❖ **Termination**

1. Consumers no longer waiting for services require the program status code to be modified to termination.

2. Termination for APPL occurs if the person is no longer interested in waiting for services, is no longer able to receive services, begins receiving services, or begins the eligibility process.

Revision History:

Revision	Date	Description of changes	Requested By
1	**9/14/2007**	**Established ARC Waitlist Procedures**	**Katie Parkinson, Senior Program Manager**
2	**11/26/2007**	**Updated Imminent Risk procedures to allow immediate service implementation upon assessment with Care Plan Review to take place within 5 days of program enrollment.** **Updated waitlist enrollment for lead agencies.**	**Katie Parkinson, Senior Program Manager**
3	**5/14/2008**	**In conjunction with WCFAA NOI #051408 and correlating DOEA NOI #041708-1-I-SWCBS updated to include dual enrollment (ACTV & APCL) 701B reassessment and update requirements.** **Updated to describe Lead Agency requirements for CIRTS Enrollment process for updating APPL status lines.** **Included process for Lead Agency to return authorized consumer to waiting list due to low priority score.** **Updated to include Termination procedures.**	**Katie Parkinson, Senior Program Manager**
4	**12/18/2008**	**Updated to revise procedures to**	**Katie Parkinson, Director**

		allow care planned services that do not exceed risk level targeted values to be implemented prior to WCFAAA approval.	**of Program Management**

PUOP# BUDGET003 Revision: 3 **Prepared By: KP**
Effective Date: 12/18/2008 **Approved By: GDS**

Title: State General Revenue Care Plan Review Procedure

Policy: The ARC Enrollment Manager will review all care plans for newly enrolled consumer care plans and established consumer care plans that exceed the thresholds for the PSA target values by risk level as indicated below.

Purpose: To outline the methods to assist in predicting and controlling cost, quality of care, standardization of client services PSA wide. The goal is to provide quality services in the most cost effective and efficient manner.

Scope: This procedure applies to all State General Revenue funded consumer care plans.

Responsibilities: A care plan review team has been established. The ARC Enrollment Manager has been designated as the team leader along with participation from a WCFAAA program manager and a lead agency representative. The lead agency will have the responsibility for submitting all care plans, along with assurance that funding is available to support request, to the ARC Enrollment Manager for approval prior to service initiation or increases.

Procedure:

1. A care plan review team will be developed consisting of at least case management supervisor from the lead agency, the designated WCFAAA program manager and ARC Enrollment Manager.

2. The case management agency will ensure that case managers will develop care plan services which are consistent in quantity and frequency with the client's assessed need.

3. The case manager must document in the case narrative all attempts to access non-DoEA funded resources including family members, state plan Medicaid benefits, OAA services, community services, etc.

4. The case manager must be cognizant of the PSA target value by risk level for each care plan that is developed and make every effort to remain within the targeted amount while providing the necessary services. The PSA targeted care plan costs represents a 10% reduction to the allowable Medicaid Waiver targeted care plan costs established by the DOEA.

5. The PSA target values by risk level are as follows:

If the Risk Score is			
Greater than this value	**and less than or equal to this value**	**then this is the risk level**	**Annual Estimated Care Plan Cost**
0	**7**	**1**	**$3,493.92**
7	**15**	**2**	**$5,646.30**
15	**26**	**3**	**$7,246.17**
26	**52**	**4**	**$9,673.18**
52	**100**	**5**	**$14,270.86**

6. The case management agency will reconcile billing monthly through subcontracted vendor billing and provide oversight of billing adjustments.

7. The care plan target values are intended to provide a guideline to reasonable SGR monthly costs for persons of that risk category.

8. **Newly Referred SGR Consumers**

   a. The completed Care Plan Protocol Review Request (Form # WCFMW 23) is to be forwarded to the WCFAAA ARC Enrollment Manager at the initial intake of consumer to request authorization, regardless of priority or risk score criteria.

   b. The Request must provide assurance that funding is available for services and shall ensure that requested services are needed and justified.

   c. The Case Manager will have **five business days** from the date of the assessment to forward the care plan review staffing request to the ARC Enrollment Manager.

   d. With the exception of High Risk APS and CARES Imminent Risk consumers, services that exceed the risk level targeted values will not be initiated prior to approval by WCFAAA, unless delaying services would cause harm to the consumer. Care planned services that are at or below the risk level targeted values may be implemented prior to approval by WCFAAA. It is not the intent of the care plan review process to delay crisis resolving services to any consumer in need.

   e. Services to High Risk APS and CARES Imminent Risk consumers may be served prior to the care plan staffing request approval due to the at risk nature of these types of referrals. Services are to be put into place immediately.

   f. High Risk APS consumers that require continued services past 30 days shall be routed through the care plan review procedure. Services shall remain in effect during the staffing process.

   g. Imminent Risk consumers shall be routed through the care plan review procedure within 5 days of service implementation.

   h. The care plan review team will review the care plan staffing request and supporting documentation. The ARC Enrollment Manager will have 5 days from receipt of care plan staffing request to approve/deny or request additional supporting documentation from the case manager.

   i. The case manager will initiate services within 5 days from receipt of approval from the ARC Enrollment Manager.

   j. The ARC Enrollment Manager will track the anticipated services start date and care plan costs for utilization of waitlist management.

9. **Active SGR Consumers**

   a. If the care plan exceeds the targeted value for the risk level and has not already been approved through the Care Plan Protocol Review process by WCFAAA, the case management supervisor must review the care plan within 7 business days of the semi-

annual or annual reassessment. This supervisory review of the care plan must be documented in the case narrative along with a detailed explanation of approval of the assessed service and frequency based on the client's need. The case management supervisor must provide assurance to WCFAAA that funds are available to cover services requested and refer on-going client care plans that exceed the PSA target values in State General Revenue Funded Programs to the WCFAAA Program Manager using the Care Plan Protocol Review Request Form# WCFMW 23. Once a level of care planned services has been approved by WCFAAA further approvals are not necessary unless units of service are to be increased.

b. The care plan review team will evaluate all increases to the care plan staffing requests that exceed the PSA Targeted Care Plan Cost Guidelines.

c. SGR clients who are eligible to transfer into the Medicaid Waiver funded program will require that a Medicaid Waiver Funding Approval Request Form (Form# WCFMW 22) be submitted. CIRTS should be updated to reflect an APCL enrollment status in MW.

d. The completed Care Plan Protocol Review Request (Form # WCFMW 23) providing assurance that funding is available for services requested along with assurance that authorized services are needed and justified is to be forwarded to the WCFAAA immediately after identifying a consumer need not currently addressed on the care plan.

e. The care plan review team will review the staffing request to ensure that authorized services are needed and justified. The care plan will be reviewed to ensure maximum utilization of non-DoEA funded services, including community resources, OAA and LSP.

f. If it is determined that the identified services can potentially be provided more cost effectively, or it is determined a non-DoEA funding source for services, the case manager will be notified in writing prior to final approval being given.

g. The ARC Enrollment Manager, in conjunction with the team members, will approve or deny care plan requests on the Care Plan Protocol Review Request form (Form# WCFMW 23).

h. If the client or representative requests to file a grievance due to any adverse action, the case manager will follow all contract grievance procedures. Current service delivery will remain in place in accordance with the established procedures. Any adverse action will only be initiated once the entire grievance process is complete.

10. Authorization of Client Services

a. The case manager will only authorize those services in the quantity and frequency which is consistent with the need of the client.

b. The case management agency must implement a tracking mechanism for all SGR clients to ensure they do not exceed their monthly aggregate budget based on their annual spending authority. This tracking mechanism will include individual care plan costs and be used to maintain communication with the ARC for enrollment management.

c. The ARC Enrollment Manager will track the anticipated services start date and care plan costs for utilization of waitlist management.

d. The ARC Enrollment Manager will run at a minimum a monthly report for waitlists to identify clients that meet priority level and are eligible for SGR funded programs.

Enrollment will occur as funding is available and according to the prioritization of service delivery as outlined in the master agreement.

e. The Area Agency will submit to DoEA a monthly surplus/deficit report in accordance with the Medicaid Waiver Specialist contract and the DoEA Master Agreement.

Revision History:

Revision	Date	Description of changes	Requested By
1	9/14/2007	Included procedures for initial authorization of care plan costs prior to services starting.	Katie Parkinson, Senior Program Manager
2	12/18/2008	Updated to revise procedures to allow care planned services that do not exceed risk level targeted values to be implemented prior to WCFAAA approval. Updated to clarify that once a level of care planned services has been approved by WCFAAA that further approvals are not required unless units of service are to be increased.	Katie Parkinson, Director of Program Management