West Central Florida
Area Agency on Aging, Inc.

Assistance. Advocacy. Answers on Aging.

CARE PLAN PROTOCOL REVIEW PROCEDURES

MEDICAID WAIVER
CARE PLAN REVIEW TEAM FORMULATION

A care plan review team will be developed consisting of the following:

A) At least one staff member from a case management agency who meets the applicable requirements and qualifications established for the Aged/Disabled Adult Waiver. This team member should not be the same person who initially referred the care plan that exceeded the statewide target values by risk level to the team.

B) The Medicaid Waiver Specialist will serve as the team leader.

C) Consultation will occur with a PSA 6 CARES Supervisor should further technical assistance be necessary. If the CARES Supervisor is unavailable, then a designated CARES alternate will be consulted.

MEDICAID WAIVER
CARE PLAN REVIEW TEAM OPERATIONAL PROCEDURES

NEW MW CLIENTS

1. To enroll a new client : A Medicaid Waiver (MW) Funding Approval Request (Form # WCFMW 22Rev1) must be submitted to the appropriate Medicaid Waiver Specialist (MWS) for each SGR client who is eligible to transfer into a Medicaid Waiver funded program. The Lead Agency will update CIRTS to reflect an APCL enrollment status in MW.

2. The MWS will authorize the case management agency to initiate procedures to Request Assistance through DCF. Within 7 business days of receipt of the authorization to begin MW Funding application process, the Lead Agency will designate the client as APPL in CIRTS. A copy of the signed authorization must be maintained in the client case record.

3. CARES: Upon receipt of the authorization to begin the MW funding application process, the Case Manager will complete and submit the paperwork necessary to obtain the Level of Care (LOC). CARES requires the 3008 Physician's Referral, Assessment and Care Plan. A copy of the LOC and 3008 must be maintained in the Client Case Record.

4. DCF: Upon receipt of the authorization to begin the MW funding application process, the Case Manager will begin processing the Request for Assistance (RFA) through DCF.

   If the RFA has been filed online, the Case Manager, must forward the LOC to DCF. DCF requires the RFA confirmation number be noted on the LOC form.

   Documentation of completed RFA is to be maintained in the Client Case Record.

5. The Case Manager will complete CF-AA 2515 with the MW funding "begin date". The completed form is to be forwarded to DCF with a copy to the MWS.

   If the RFA has been filed online, the Case Manager, must forward the CF-AA 2515 to DCF. DCF requires the RFA confirmation number be noted on the form.

   A copy of the CF-AA 2515 must be maintained in the Client Case Record.

6. A newly enrolled client's care plan will be reviewed at the semi-annual or annual review, whichever is earlier.

EXISTING MW CLIENTS:

1. The MWS and a Case Management Care Plan Review Team (CPR) member will review all care plans which exceed the statewide target values by risk level as identified in the NOI#021204-1-I-SWCBS that have not been approved. The CPR Team will review the request within 7 business days of receiving the care plan request documentation.

2. The Case Management Agency will forward the following information to the MWS for the Care Plan Review: Care Plan Protocol Review Form (Form # WCFMW 23Rev1) and a copy of the projected cost plan. Form # WCFMW 23Rev1 will include all pertinent information to ensure that authorized services are needed and justified.

   Form # WCFMW 23Rev1 will be reviewed by the CPR Team to ensure maximum utilization of non-DOEA funded services, including community resources, and state plan Medicaid covered services.

3. If the team identifies services which can potentially be provided more cost effectively, or determines that a non-DOEA funding source for services is available, the case manager will be notified in writing.

4. Upon completion of the review, the MWS will document on Form# WCFMW 23Rev1 whether the care plan was approved or denied and forward the form to the Case Management Agency. Form #WCFMW 23Rev1 is to be filed in the case file behind the care plan and care plan cost worksheet.

5. If a team member determines a service is not necessary based on the client's assessed need, or may be delivered at a reduced frequency or duration, reasons for this determination must be documented in detail on Form # WCFMW 23Rev1. The case manager may be requested to provide additional documentation or justification. The CPR Team will review the additional information and make a final determination.

6. If the client disagrees with any adverse action, they may file a grievance orally or in writing. The case manager will follow the Medicaid Waiver Grievance Procedures outlined in the Master Agreement, Attachment V. All grievance and fair hearing procedures are applicable.

7. If the client or representative requests a fair hearing due to any adverse action, the case manager will follow all Medicaid Waiver 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. The appeals process will comply with Medicaid Fair Hearing requirements as cited in 42 CFR 431 Subpart E and will in no way impede access to the Medicaid Fair Hearing process.

MEDICAID WAIVER
AUTHORIZATION OF MONTHLY EXPENDITURES FOR CASE MANAGEMENT AGENCIES

1. The case management agency will ensure that case managers develop care plan services which are consistent in quantity and frequency with the client's assessed need. Particular attention will be given to the services of clients transitioning from CCE to Medicaid Waiver to ensure that any increase in care plan services is justified and documented.

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

3. The case manager must be aware of the statewide 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. This includes all CDC care plans. The statewide target value by risk level is as follows:

If the Risk Score is		then this is the risk level	Review if the care plan exceeds this monthly target	Annual Estimated Care Plan Cost
Greater than this value	and less than or equal to this value			
0	7	1	$291.16	$3,493.92
8	15	2	$470.52	$5,646.30
16	26	3	$603.85	$7,246.17
27	52	4	$806.10	$9,673.18
53	100	5	$1,189.24	$14,270.86

4. The care plan target values are intended to provide a guideline to reasonable ADA Waiver monthly costs for persons of that risk category. Care plans in excess of these monthly target values in waiver-funded services are to be reviewed and meet medical necessity.

5. If the care plan exceeds the targeted value for the risk level, the case management supervisor must review the care plan within 7 business days of the initial assessment, 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 the client's need and medical necessity.

6. The case management supervisor must refer on-going client care plans that exceed the statewide target values in Medicaid Aged/Disabled Waiver–funded services by risk level for review by the Care Plan Review Team using the Care Plan Protocol Review Request Form # WCFMW 23Rev1. This includes the care plans of consumers in the Consumer Directed Care (CDC) program.

7. Those care plan reviews that are in excess of the Targeted Guidelines listed in Item 3 and have been approved by the Care Plan Protocol Review Team will not need to be resubmitted for review if the care planned services remain the same (this includes unit rate increases that may be adjusted). The care plan must remain the same in service and frequency. The approved Care Plan Protocol request shall be filed in the Client Case Record and remain the approved care plan authority.

MONITORING AND QUALITY ASSURANCE PROCEDURES

1. The case management agency will implement a tracking mechanism for all ADA Waiver clients to ensure they do not exceed their monthly aggregate budget based on their annual targeted budget. This tracking mechanism will include individual care plan costs.

   The tracking mechanism at a minimum must include the client's full name, SSN, risk score and care plan costs by program and service. This report must include every active MW client.

2. The case management agency will compare monthly reported expenditures and paid claims by all providers to authorized services for each client. The DOEA generated "Paid Claims Report by County/Provider" will be forwarded by WCFAAA to each case management agency when it is updated. The case management agency will report discrepancies to WCFAAA in writing within 10 business days following the receipt of the report.

   WCFAAA will utilize FMMIS, historical data, the "Paid Claims Report by County/Provider" DOEA report, and any other applicable reports to ensure compliance with the spending authority. WCFAAA will follow up with case management agencies and/or providers when reported expenditures and paid claims discrepancies are noted.

3. The Medicaid Waiver Specialist will conduct a random monthly monitoring of 10 case files from one case management agency. The MWS will monitor care plan costs and ensure that non-DOEA funded resources have been utilized when appropriate and that the targeted value guidelines for risk levels have been followed.

   The case management agency must complete service quality reviews on an ongoing basis and maintain the results in the case file. Follow up with the client or service provider is to be completed as necessary.

SPECIAL EXCEPTIONS PROCEDURES

1. If the case management agency identifies an emergency situation that will necessitate an increase to the care plan, all pertinent information should be forwarded to the MWS. Form # WCFMW 23Rev1 and a copy of the provided cost plan must be submitted. MWS will review the information and forward a written response within 3 business days.

2. The decision will be based on the necessity of the service requested. It is understood that the intent is not to encourage enrichment of care plans within the PSA, but to provide a quick response to emergency situations.

3. If approved, special exceptions will be for a specified time, not to exceed 60 days, to allow the Case Manager to implement requested services.