PUOP# BUDGET003 Revision: 9/14/07 **Prepared By: KP**
Effective Date: 6/23/2006 **Approved By: GS**

Title: State General Revenue Care Plan Review Procedure

Policy: To outline the methods to assist in predicting and controlling cost, quality of care, standardization of client services PSA wide, with the goal of quality services provided in the most cost effective, 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 is 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	$3,144
8	15	2	$5,082
16	26	3	$6,522
27	52	4	$8,706
53	100	5	$12,843

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 will not be initiated prior to approval by WCFAAA, unless delaying services would cause harm to the consumer. 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, 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.

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