CARE PLAN REVIEW PROTOCOL

The purpose of the Care Plan Review Protocol is to ensure that quality services are provided in the most cost effective and efficient manner possible while assisting clients to age in place in their communities for a lifetime.

I. *The Area Agency on Aging will:*

A. Establish and maintain at least one Care Plan Review Team in the Planning and Service Area (PSA). The team will be comprised of at least an Area Agency on Aging Medicaid Waiver Specialist and a lead agency case management staff person who complies with applicable requirements and qualification established for the Aged or Disabled Adult Services Waiver. If the team determines a need for further deliberation or technical assistance, the area CARES office may be consulted.

B. Ensure that care plans are developed based upon the assessed needs of the client and that the cost of a client's care plan is determined based upon the monthly statewide target.

C. Ensure that care plans initially developed and updated are within the statewide target values in Medicaid Aged/Disabled Waiver-funded services for the client's risk level. Care plans that exceed the statewide target values for the clients' risk levels are to be reviewed based on client's identified needs and, if appropriate, approved.

D. Conduct client file reviews on a monthly basis. Client files will be reviewed to ensure utilization of non-DOEA funded community resources, the State Medicaid Plan and other programs, including OAA and Local Service Programs.

E. On a monthly basis, send the Department the surplus/deficit report in accordance with the Medicaid Waiver Specialist contract and the DOEA Master Agreement.

F. Authorize all client enrollments into the ADA and ALE Waiver programs.

G. Authorize monthly expenditures for care plans that each Lead Agency cannot exceed without approval from the AAA or the Care Plan Review Team.

II. *The Lead Agency will:*

A. During semi-annual care plan reviews, annual re-assessments, and any special review, require that case managers ensure the following:

1. The care plan services are consistent in quantity and frequency with the client's assessed needs. Particular attention will be given to the services of consumers transitioning from Community Care for the Elderly (CCE) to Medicaid Waiver to ensure that any increase in care plan services is justified and documented.

2. The care plan includes non DOEA-funded services and incorporates assistance from caregivers and other family members when feasible.

3. The care plan includes services funded by the State Medicaid Plan and the Older Americans Act (OAA) when appropriate.

B. Ensure the case management supervisor refers 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. This includes the care plans of consumers enrolling in the Consumer Directed Care (CDC) program.

C. Ensure participation in DOEA and AAA sponsored training related to case management, care plan development, and assessment completion.

D. Ensure the monthly aggregate budget determined by the AAA will not be exceeded without approval.

III. *The Care Plan Review Team will:*

A. Meet at least monthly to review the individual care plan, assessment and other relevant information for each client whose case is referred for review. Client files will be reviewed to ensure utilization of non-DOEA funded community resources, the State Medicaid Plan and other programs, including OAA and Local Services Programs.

B. Be responsible for working with the case manager to explore cost effective alternatives for services that exceed the established care plan target value for the client's risk level prior to approval of the care plan.

C. Provide written justification for approval or denial of any amount that exceeds the care plan target value in Medicaid Aged/Disabled Waiver-funded services for the client's risk level based on the results of the review.

IV. *Care Plan Cost*

In developing and updating care plans, the case manager will use the following table to determine when review and approval as outlined above is necessary. The care plan target values were calculated based on the nursing home risk scores of the total ADA population during SFY 2002-2003. The risk score is derived from the DOEA comprehensive assessment form. This score measures the risk of nursing home placement and generally increases over time with frailty. Unlike the priority ranking, that is based upon the priority score, it is unaffected by any services. The care plan target values are intended to provide a guideline to reasonable Medicaid Aged/Disabled Waiver monthly costs for persons of that risk category. Care plans in excess of these monthly target values in Medicaid Aged/Disabled Waiver-funded services are to be reviewed and clinically justified.

If the Risk Score is		then this is the risk level	Review if the care plan exceeds this monthly target
Greater than this value	and less than or equal to this value		
0	7	1	$282.68
8	15	2	$456.82
16	26	3	$586.26
27	52	4	$782.62
53	100	5	$1,154.60

V. *Process For Special Exceptions:*

A. An Area Agency on Aging may make a request to the Department for an adjustment to the monthly care plan cost review targets for its Planning and Service Area. However, it is not the intent to encourage enrichment of care plans in PSAs that have some counties with average costs lower than the statewide targets.

B. The AAA must outline a grievance and appeals procedure for any Lead Agency and/or client who believes that the Care Plan Review Team decision has adversely impacted a client's health and safety.

C. The AAA must ensure the appeals process complies with Medicaid Fair Hearing requirements as cited in 42 CFR, 431 Subpart E, and in no way impedes access to the Medicaid Fair Hearing process.