ALLOCATION OF RESOURCES TO COUNTY AGENCIES

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The county agency budget allocation allows county agencies to plan and meet recipients' service needs with greater flexibility and local control. County agencies authorize waiver and State plan home care services within their budget allocations. Providers are paid through MMIS.

The Department will provide the necessary safeguards to protect the health and welfare of people using the waiver. County agencies continue to be responsible to offer and make available feasible home and community-based support options to eligible recipients within available resources.

Profile Methodology

The methodology used to calculate funding for new waiver recipients (i.e., to fund new slots) is based on four broad recipient profiles established in 1995. The recipient profiles were developed through an extensive empirical analysis of recipient characteristics including the:

(1) level of self care support needed, and
(2) intensity of aggressive and/or destructive behavior, if any; and,
(3) presence of a diagnosis of mental illness combined with observable obstructive behavior.

This data was used to establish average levels of funding resources available for each of the four recipient profiles. The Department may adjust the recipient profile resource amounts based on recipient characteristics and cost analysis. The profile amounts for calendar year 2003 and thereafter will be based on the average daily waiver and State plan home care service costs paid in state fiscal year 2000 for waiver recipients in that profile.

County Agency Budget Allocations

The Department will establish and adjust county agencies' budget allocations. These budget allocations establish the maximum amount of Medical Assistance funding available for waiver and State plan home care services for recipients who are the financial responsibility of that county agency. County agencies will be notified by the Department of the budget allocation available to serve waiver recipients (who are the financial responsibility of their county). The budget allocation amounts will be determined as follows.

1) Base Budget Allocations for Calendar Year 2003

Effective January 1, 2003, each county agency will receive a base budget allocation for MR/RC waiver services including State plan home care services authorized for waiver recipients. Within the budget allocation, county agencies shall authorize waiver and State plan home care services to recipients who are the financial responsibility of their county.

The base budget allocation effective January 1, 2003, will include five components:

(a) Paid claims, based on service date, for recipients' waiver and state plan home care for state fiscal year 2002 including an adjustment for two-tenths of a percent to account for outstanding payments, and an adjustment for the annualization of costs for state fiscal year 2002 recipients equivalent to 3.2% of the state fiscal year 2002 paid claims;
(b) A three percent provider cost of living increase authorized in state law;
(c) A factored amount for changes in recipients' service intensity equivalent to 1% of the estimated waiver and state plan home care spending for existing recipients;
(d) Funding to pay for the additional service costs related to institutional closure or other agreements approved by the Department prior to December 31, 2002; and,
(e) Annualization of recipient's profile amounts for people who received an additional waiver slot between July 1, 2002 and December 31, 2002. The annualization will equal the recipient profile amount multiplied by 365.

(2) Annual Budget Allocations for Calendar Year 2004 and Thereafter

For budget allocations effective January 1, 2004 and thereafter, county agency's annual budget allocations will be based on method A or B, whichever results in a lower budget allocation.

Method A includes:

(a) The previous year's budget allocation'
(b) Rate or limit changes required by state law;
(c) Annualization of recipient profile amounts for recipients who began waiver services during the previous calendar year (i.e., new waiver recipients with an additional waiver slot). The annualization applies only to the recipient's first partial waiver service year after which, the recipient's waiver and State plan home care costs are accounted for in the ongoing budget allocation. The annualization will equal the recipient profile amount multiplied by 365; and,
(d) A factored amount for changes in recipients' service intensity equivalent to 1% of the estimated waiver and state plan home care spending for existing recipients applied to (a) through (c) of this paragraph.

Method B includes:

(a) The most recently completed state fiscal year paid claims including two-tenths of a percent to account for outstanding payments;

(b) Annualization of recipients who began waiver services during the previous calendar year (i.e., new waiver recipients with an additional waiver slot and those who reused a slot). The annualization applies only to recipient's first partial waiver service year after which, the recipient's waiver and state plan home care costs are accounted for in the ongoing budget allocation. The annualization will equal the recipient's average daily cost for waiver and state plan home care multiplied by 365;
(c) Rate or limit changes required by state law;
(d) The reserve amount set aside by the county agency, not to exceed five percent of the most recent state fiscal year paid claims for that county agency; and,
(e) A factored amount for changes in recipients' service intensity equivalent to 1% of the estimated waiver and home care spending for existing recipients applied to (a) through (c) of this paragraph.

(3) Adjustments to the Base and Annual Budget Allocations

The Department may adjust the county agencies' budget allocation to : serve additional recipients (i.e., to fund additional waiver slots); respond to recipient moves between counties (i.e., when a recipient's county of financial responsibility changes); implement changes required by state law; and, support recipients moving from institutions.

Funding of additional waiver slots will be based on the individual recipient's profile amount multiplied by the expected number of waiver service days for the current calendar year. If a recipient discontinues or is otherwise ineligible for waiver services, the budgeted allocation amount attributable to that recipient may be retained by the county of financial responsibility in their budget allocation.

The Department may rebase county agencies' budget allocations, as necessary, based on the relationship between the county agency's budget allocation and actual waiver and State plan home care service costs.

County Agency Budget Allocation Management

1) Recipient Prioritization

If a county agency is not able to provide waiver services to all eligible individuals, they must develop a waiting list. The county agency shall establish policies and procedures to manage and prioritize the waiting list.

These policies and procedures must be submitted to the Department for approval initially and prior to any revision being implemented. The policies and procedures must be available to the public upon request.

The prioritization of individuals to be served on the waiver must comply with state law including preventing institutionalization.

2) Individual Service Plans (ISPs)

County agencies are responsible to develop recipients care plans, "Individual Service Plans (ISP)," within the available budget allocation. The ISP will include all waiver and State plan home care services necessary to avoid institutionalization. The plan must assure the recipient's health and safety and be authorized by the county agency.

Recipients, who are using the waiver and are otherwise eligible, shall not be terminated from the waiver by a county agency for the sole purpose of the county agency's management of their budget allocation.

3) Waiver and State Plan Home Care Service Changes

The county agency shall not authorize Medical Assistance funding for waiver or State plan home care services beyond its budget allocation including accounting for future needs of current recipients. If a county agency wishes to reevaluate an ISP, it must follow Minnesota Rules, Parts, 9525.0004 to 9525.0036 and instructions provided by the Department. All applicable recipient notification and appeal rights apply.

4) Serving Additional Recipients

County agencies may serve additional people within their budget allocation (i.e., without the Department adjusting the budget allocation for additional slots). If a recipient leaves the waiver, a county agency may use the funds provided in its budget allocation for that individual to add waiver recipients or address the needs of current waiver recipients.

5) Reserve Amounts

County agencies must have and submit to the Department a plan to address changes in recipient's needs, including anticipated, unexpected and emergency needs, within their budget allocation. This plan shall be available to the public upon request.

County agencies may elect to establish a reasonable reserve amount to address these recipient needs. The reserve amount must be based on the county agency's experience, recipient utilization history and anticipated recipient needs.

B-1 Service Description

_____CRISIS-RESPITE

Crisis-respite services are specialized services which provide short-term care and intervention to an individual due to the need for relief and support of the caregiver and protection of the recipient or others living with the recipient. When out-of-home crisis-respite is used, long-term strategies are to be developed to prevent reoccurrence. Crisis-respite services will include the following recipient specific activities:

A) Assessment to determine the precipitating factors contributing to the crisis.
B) Development of a provider intervention plan in coordination with the service planning team.
C) Consultation and staff training to the provider(s) and/or caregiver(s) as necessary to assure successful implementation of the recipient specific intervention plan.
D) Development and implementation of a transition plan to aid the recipient in returning home if out of home crisis-respite was provided.
E) On-going technical assistance to the caregiver or provider in the implementation of the intervention plan developed for the recipient.
F) Provision of recommendations for revisions to the 24-hour plan of care (individual service plan) to prevent or minimize future crisis situations in order to increase the likelihood of maintaining the recipient in the community.

Crisis-respite services provide specific intervention strategies directed towards enabling the recipient to remain in the community. These services are a necessary service component of the 24-hour plan of care that is developed and monitored by the case manager and, as such, do not duplicate those services provided through case management.

Crisis-respite services can either be provided to the recipient living in his or her home or, when necessary for the relief of the caregiver and the protection of the recipient or others living in the home, in a specialized licensed foster care facility developed for the purpose of providing short-term respite and crisis intervention. Payment for out-of-home crisis-respite will include payment for room and board costs when the service is provided in a licensed foster care facility developed for the provision of crisis-respite that is not a private residence.

The following criteria must be met for a recipient to receive crisis-respite services:

A) The caregiver and service providers are not capable of providing the necessary intervention and protection of the recipient or others living with the recipient.
B) The crisis-respite service(s) will enable the recipient to avoid institutional placement.
C) The will not result in the recipient's inability to return home or to an alternative home in the community, and that the continued use of the crisis-respite service is a cost-effective alternative to institutionalization.
D) The recipient has been screened and authorized as eligible to receive home and community-based services. Unlike other waivered services, the crisis-respite service must be immediately available to a recipient as an alternative to institutional placement. Because of this, the determination of eligibility and modifications to the plan of care may occur within five working days of receiving crisis-respite services. However, no Medicaid payment will be made if the screening process determines that the recipient is not eligible for home and community-based services. The screening process is the same and uses the same instrument as used for all evaluations of eligibility for ICF/MR or home and community-based services.

Crisis-respite services will be offered in areas of the state authorized in accordance with Minnesota law. All local county agencies and providers of crisis services seeking Medicaid home and community-based reimbursement for crisis-respite services must have a provider agreement approved by the local county agency's board. The provider agreements will specify local agencies' responsibilities, provider responsibilities, the services to be provided, the network of specialized service providers to be utilized, how the utilization and effectiveness will be monitored, and how the overall Medicaid cost-effectiveness of the service will be assured. The provider agreement must be kept on file with the local county agency.