Minnesota Department of **Human Services**

Memo

DATE: July 1,2004

TO: County Human Services Directors

FROM: Shirley York
Director, Disability Services

SUBJECT: Lawsuit Settlement

The Department of Human Services ("DHS") has recently settled one of the two lawsuits filed in federal court regarding the rebasing of the MR/RC waiver. As part of the settlement, DHS agreed to provide counties with guidelines related to the administration of home and community based services for persons with mental retardation or related conditions. The attached guidelines provide information to counties regarding three issues:

- County procedures for allocating funding available to individual recipients;
- Required notifications and obligations of the county when proposing amendments to individual service plans and/or recipients' budgets; and
- Considerations when deciding to add new recipients to the waiver program.

The information in this memo will also be available on the DHS web site by October 1, 2004, and training for case managers concerning these guidelines will be made available on-line by July 1, 2005. If you have questions regarding the contents of the guidelines, please contact your regional resource specialist for assistance.

Finally, I want to express our thanks for the work you are doing to protect consumers and for your efforts toward good financial stewardship of public dollars. We realize that the changes in this waiver program have placed a hardship on county staff. It has required counties to tighten their fiscal management, modify policies and procedures, and reassess future planning. We share with you an interest in a budget allocation system that provides stability and predictability for the purposes of managing this program. We look forward to working with you on future changes that will better meet that goal.

County Guidelines for Allocating Resources for Individuals

The county agency is responsible in two ways for case management. The first way is an administrative function that addresses eligibility, screening for services, and authorization of funding. The second is the function of planning, assisting the recipient in accessing services, and monitoring the services to insure the appropriate outcome.

The individual service plan is an essential document of both of these functions. It is the means of documenting what is needed for services, what outcomes are expected, what will be authorized, how long the authorization will remain in force, and what obligations the parties have in the course of implementing services. State and federal law require that choices be given to consumers/legal representatives, that full participation in the development of the plan be afforded to the consumer/legal representative and that all plans and amendments to plans be signed by the county and the recipient. It is incumbent upon the parties involved to be as clear as possible about the type/scope/duration of services, the level of service that will be authorized, and any conditions about the approval of the services.

Many counties use some type of tool or procedure in assigning budget resources to implement an individual recipient service plan. These tools and procedures generally consider factors such as level and type of disability, need for supervision and support, the type of living arrangement, and other needs such as environmental modifications. These tools are very useful as a means to advise county staff about the usual costs of similar service packages for people with similar characteristics. These tools and procedures also help decision makers within a county make reasonable and equitable decisions when considering authorizations for any particular recipient, residence, or other service type.

Because each individual is unique and the individual's service plan is based upon a combination of factors associated with the needs and preferences of the recipient, counties may not cap resources simply on the basis of the tool or procedure.[1] Neither may a county use the amount of money provided by DHS to the county pool (which occurs each time a new slot is added) as either an entitlement or a cap for the person.

The critical factor for the assignment of funds is what the county and the recipient/legal representative have agreed to do in the service plan itself. Limits on the extent of service or funding should be discussed and decided as a part of the service plan process, using guidelines that the county has established. Services needed to insure health, safety, or welfare may not be restricted because of budget limits. Services that are needed to meet the objectives of the service plan must be provided within the limits the county has agreed to in the plan. Services that are desirable merely because they provide an enhanced quality of life above what is necessary do not have to be funded, but may be if agreed to in the plan.

Amending Individual Service Plans and/or Recipients' Budgets

It will be necessary from time to time to make changes in the recipient service plans. For instance, the recipient/legal representative has the right to request a reassessment of need if it is believed that the services no longer are meeting the needs that exist, when needs have increased, or when another change is desired. Or it may be county-initiated in instances where the county finds that services previously authorized are not meeting needs, are not being used, or are not actually needed. Changes may be made at any time when parties can agree. But in the case of changes where the parties do not agree, other steps must be taken.

Counties recommending a change of service plan must propose that change on the basis of individual need, and the individual's budget may not be reduced below the amount needed to ensure medically necessary services to meet the recipient's health, safety, and welfare. Minn. Stat. § 256B.092, subd. 5(c). Prior to proposing any reduction, the county must offer to review the individual's service plan with the individual, to assess both the individual's current level of need and the prioritization of service needs within the service plan. Minn. Stat. § 256B.092, subd. 5(c). Where available, existing assessments of service needs (for example, recent PCA or nursing assessments, DT&H plans, etc.) must be reviewed to assure that any proposed change does not reduce services below the level necessary to meet previously identified needs. In some cases, it may be necessary to obtain new assessments to assure that the individual's present level of need has been accurately determined.

Across the board reductions to recipients in a county are not generally favored and cannot occur in any case without these prior individual reviews. Notification must be given to each recipient/legal representative, and the county must assure that the recipient/legal representative is aware of the right to appeal a proposed action. In the event of an appeal, services must continue until there is a decision made about the appeal or unless the parties can reach agreement. Finally, if there is a change of eligibility or significant changes in the needs or services planned, a new full team screening is required.

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[1] Counties, however, must abide by caps established by DHS under the CDCS Amendment that becomes effective October 1, 2004.

Considerations for Adding New Recipients to the Waiver Program

Minnesota statutes direct county agencies to prioritize their MR/RC waiting list on the basis of specific criteria described in rule and law. For example, priority consideration must be given to persons living in ICF/MR settings and persons whose living situations are unstable due to the age or incapacity of the primary caregiver and to children to avoid out-of-home placement. Minn. Stat. § 256B.0916, subd. 5 (d). In addition to this, counties must have policies and procedures in place describing how these laws will be implemented. These policies and procedures must be available for public review.

Beyond these rules, laws, policies and procedures, a county must also consider the following factors when determining assignment of slots to people waiting for services. These factors include:

- Can the necessary supports and services identified in the service plan be accommodated by the county waiver budget?
- Can the county assure the health, safety, and welfare of the consumer, and reasonably assure such health, safety, and welfare into the future?
- Can the county and consumer access providers who meet standards and competency requirements stated in the service plan?
- Does the county anticipate having a surplus at the end of the budget year?
- What budget reserves will be needed to meet anticipated or unanticipated changes in current recipient needs within the budget year?
- In assessing the adequacy of the county's budget reserves, the county should consider its historical spending data and trends; the demographics of its current waiver population (e.g. whether the county has a high number of persons expected to leave the school system in the current year and need DT&H services, etc.); and recent changes in the law or other service programs that could increase demand for waiver services among current recipients.
- How will likely turnover in the program impact the budget of the county?

The county is not obligated to provide waivered services to all eligible people on its waiting list. The county must, however, provide all medically necessary services to current recipients to assure that their health, safety, and welfare needs are met. Counties must also assist the state in complying with its obligations under the Americans with Disabilities Act and the *Olmstead* decision to avoid unnecessary institutionalization by providing services in the most integrated settings appropriate for consumers. Therefore, it is critical that each county make decisions about the feasibility of adding new recipients both on the basis of current and anticipated needs of consumers balanced against the urgent need of those who are waiting for services.