SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 884

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DATE	D-PG	OFFICIAL STATUS
03/17/2011	543	Introduction and first reading Referred to Health and Human Services See SF760, Art. 6, Sec. 11, 19, 21-24, 33-34, 38, 40, 41-42 (vetoed) See HF25, Art. 7, Sec. 39 (First Special Session) See SF1675, Art. 11, Sec. 25, 27, 29, 33, 38, 40-42

A bill for an act

relating to human services; modifying the self-directed supports option for elderly and disabled individuals; requiring a report; amending Minnesota Statutes 2010, sections 256.045, subdivision 4a; 256B.0657; 256B.0911, subdivisions 1a, 3a; 256B.0916, subdivision 6a; 256B.092, subdivisions 1a, 1b, 1e, 1g, 3, 8, 8a; 256B.49, subdivisions 13, 14, 15; 256G.02, subdivision 6.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2010, section 256.045, subdivision 4a, is amended to read:

Subd. 4a. **Case management ~~appeals~~ temporary stay of demission.** ~~Any recipient of case management services pursuant to section 256B.092, who contests the county agency's action or failure to act in the provision of those services, other than a failure to act with reasonable promptness or a suspension, reduction, denial, or termination of services, must submit a written request for a conciliation conference to the county agency. The county agency shall inform the commissioner of the receipt of a request when it is submitted and shall schedule a conciliation conference. The county agency shall notify the recipient, the commissioner, and all interested persons of the time, date, and location of the conciliation conference. The commissioner may assist the county by providing mediation services or by identifying other resources that may assist in the mediation between the parties. Within 30 days, the county agency shall conduct the conciliation conference and inform the recipient in writing of the action the county agency is going to take and when that action will be taken and notify the recipient of the right to a hearing under this subdivision. The conciliation conference shall be conducted in a manner consistent with the commissioner's instructions. If the county fails to conduct the conciliation conference and issue its report within 30 days, or, at any time up to 90 days after the conciliation~~

~~conference is held, a recipient may submit to the commissioner a written request for a hearing before a state human services referee to determine whether case management services have been provided in accordance with applicable laws and rules or whether the county agency has assured that the services identified in the recipient's individual service plan have been delivered in accordance with the laws and rules governing the provision of those services. The state human services referee shall recommend an order to the commissioner, who shall, in accordance with the procedure in subdivision 5, issue a final order within 60 days of the receipt of the request for a hearing, unless the commissioner refuses to accept the recommended order, in which event a final order shall issue within 90 days of the receipt of that request. The order may direct the county agency to take those actions necessary to comply with applicable laws or rules.~~ The commissioner may issue a temporary order prohibiting the demission of a recipient of case management services under section 256B.092 from a residential or day habilitation program licensed under chapter 245A, while a county agency review process or an appeal brought by a recipient under this subdivision is pending, or for the period of time necessary for the county agency to implement the commissioner's order. The commissioner shall not issue a final order staying the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A.

EFFECTIVE DATE. This section is effective January 1, 2012.

Sec. 2. Minnesota Statutes 2010, section 256B.0657, is amended to read:

256B.0657 SELF-DIRECTED SUPPORTS OPTION.

Subdivision 1. **Definition.** (a) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph (d).

(b) "Legal representative" means a legal guardian of a child or an adult, or parent of a minor child.

(c) "Managing partner" means an individual who has been authorized, in a written statement by the person or the person's legal representative, to speak on the person's behalf and help the person understand and make informed choices in matters related to identification of needs and choice of services and supports and assist the person to implement an approved support plan.

(d) "Self-directed supports option" means personal assistance, supports, items, and related services purchased under an approved budget plan and budget by a recipient.

Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person who:

3.1 (1) is a recipient of medical assistance as determined under sections 256B.055,
3.2 256B.056, and 256B.057, subdivision 9;
3.3 (2) is eligible for personal care assistance services under section 256B.0659, or
3.4 for a home and community-based services waiver program under section 256B.0915,
3.5 256B.092, or 256B.49, or alternative care under section 256B.0913;
3.6 (3) lives in the person's own apartment or home, which is not owned, operated, or
3.7 controlled by a provider of services not related by blood or marriage;
3.8 (4) has the ability to hire, fire, supervise, establish staff compensation for, and
3.9 manage the individuals providing services, and to choose and obtain items, related
3.10 services, and supports as described in the participant's plan. If the recipient is not able to
3.11 carry out these functions but has a legal guardian, managing partner, or parent to carry
3.12 them out, the guardian, managing partner, or parent may fulfill these functions on behalf
3.13 of the recipient; and
3.14 (5) has not been excluded or disenrolled by the commissioner.
3.15 (b) The commissioner may disenroll or exclude recipients, including guardians ~~and~~,
3.16 parents, and managing partners under the following circumstances:
3.17 (1) recipients who have been restricted by the Primary Care Utilization Review
3.18 Committee may be excluded for a specified time period;
3.19 (2) recipients who exit the self-directed supports option during the recipient's
3.20 service plan year shall not access the self-directed supports option for the remainder of
3.21 that service plan year; and
3.22 (3) when the department determines that the recipient cannot manage recipient
3.23 responsibilities under the program.
3.24 Subd. 3. **Eligibility for other services.** Selection of the self-directed supports
3.25 option by a recipient shall not restrict access to other medically necessary care and
3.26 services furnished under the state plan medical assistance benefit~~, including home care~~
3.27 ~~targeted case management~~, except that a person ~~receiving~~ choosing agency-provided
3.28 home and community-based waiver services, agency-provided personal care assistance
3.29 services, a family support grant, or a consumer support grant is not eligible for funding
3.30 under the self-directed supports option.
3.31 Subd. 4. **Assessment requirements.** (a) The self-directed supports option
3.32 assessment must meet the following requirements:
3.33 (1) it shall be conducted ~~by the county public health nurse or a certified public health~~
3.34 ~~nurse under contract with the county~~ consistent with the requirements of personal care
3.35 assistant services under section 256B.0659, subdivision 3a; home and community-based
3.36 waiver services programs under section 256B.0915, 256B.092, or 256B.49; and the

4.1 alternative care program under section 256B.0913, until section 256B.0911, subdivision
4.2 3a, has been implemented;
4.3 (2) it shall be conducted face-to-face in the recipient's home initially, and at least
4.4 annually thereafter; when there is a significant change in the recipient's condition; and
4.5 when there is a change in the person's need for ~~personal care assistance~~ services under the
4.6 programs listed in subdivision 2, paragraph (a), clause (2). A recipient who is residing in a
4.7 facility may be assessed for the self-directed support option for the purpose of returning
4.8 to the community using this option; and
4.9 (3) it shall be completed using the format established by the commissioner.
4.10 (b) The results of the personal care assistance assessment and recommendations
4.11 shall be communicated to the commissioner and the recipient ~~by the county public health~~
4.12 ~~nurse or certified public health nurse under contract with the county~~ as required under
4.13 section 256B.0659, subdivision 3a. The person's annual and self-directed budget amount
4.14 shall be provided within 40 days after the personal care assessment or reassessment, or
4.15 within ten days after a request not related to an assessment.
4.16 (c) The lead agency responsible for administration of home and community-based
4.17 waiver services under section 256B.0915, 256B.092, or 256B.49, and alternative care
4.18 under section 256B.0913 shall provide annual and monthly self-directed services budget
4.19 amounts for all eligible persons within 40 days after an initial assessment or annual review
4.20 and within ten days if requested at a time unrelated to the assessment or annual review.
4.21 Subd. 5. **Self-directed supports option plan requirements.** (a) The plan for the
4.22 self-directed supports option must meet the following requirements:
4.23 (1) the plan must be completed using a person-centered process that:
4.24 (i) builds upon the recipient's capacity to engage in activities that promote
4.25 community life;
4.26 (ii) respects the recipient's preferences, choices, and abilities;
4.27 (iii) involves families, friends, and professionals in the planning or delivery of
4.28 services or supports as desired or required by the recipient; and
4.29 (iv) addresses the need for personal care assistance services identified in the
4.30 recipient's self-directed supports option assessment;
4.31 (2) the plan shall be developed by the recipient, legal representative, or ~~by the~~
4.32 ~~guardian of an adult recipient or by a parent or guardian of a minor child,~~ managing
4.33 partner, and may be assisted by a provider who meets the requirements established for
4.34 using a person-centered planning process and shall be reviewed at least annually upon
4.35 reassessment or when there is a significant change in the recipient's condition; and

5.1 (3) the plan must include the total budget amount available divided into monthly
5.2 amounts that cover the number of months of personal care assistance services or home
5.3 and community-based waiver or alternative care authorization included in the budget.
5.4 A recipient may reserve funds monthly for the purchase of items that meet the standards
5.5 in subdivision 6, paragraph (a), clause (2), and are reflected in the support plan. The
5.6 amount used each month may vary, but additional funds shall not be provided above the
5.7 annual personal care assistance services authorized amount unless a change in condition
5.8 is documented.

5.9 (b) The commissioner or the commissioner's designee shall:

5.10 (1) establish the format and criteria for the plan as well as the provider enrollment
5.11 requirements for providers who will engage in outreach and training on self-directed
5.12 options, assist with plan development, and offer person-centered plan support services;

5.13 (2) review the assessment and plan and, within 30 days after receiving the
5.14 assessment and plan, make a decision on approval of the plan;

5.15 (3) notify the recipient, ~~parent, or guardian~~ legal representative, or managing partner
5.16 of approval or denial of the plan and provide notice of the right to appeal under section
5.17 256.045; and

5.18 (4) provide a copy of the plan to the fiscal support entity selected by the recipient
5.19 from among at least three certified entities.

5.20 Subd. 6. **Services covered.** (a) Services covered under the self-directed supports
5.21 option include:

5.22 (1) personal care assistance services under section 256B.0659, and services under
5.23 the home and community-based waivers, except those provided in licensed or registered
5.24 settings; and

5.25 (2) items, related services, and supports, including assistive technology, that increase
5.26 independence or substitute for human assistance to the extent expenditures would
5.27 otherwise be used for human assistance.

5.28 (b) Items, supports, and related services purchased under this option shall not be
5.29 considered home care services for the purposes of section 144A.43.

5.30 Subd. 7. **Noncovered services.** Services or supports that are not eligible for
5.31 payment under the self-directed supports option include:

5.32 (1) services, goods, or supports that do not benefit the recipient;

5.33 (2) any fees incurred by the recipient, such as Minnesota health care program fees
5.34 and co-pays, legal fees, or costs related to advocate agencies;

5.35 (3) insurance, except for insurance costs related to employee coverage or fiscal
5.36 support entity payments;

6.1 (4) room and board and personal items that are not related to the disability, except
6.2 that medically prescribed specialized diet items may be covered if they reduce the need for
6.3 human assistance;
6.4 (5) home modifications that add square footage, except those modifications that
6.5 configure a bathroom to accommodate a wheelchair;
6.6 (6) home modifications for a residence other than the primary residence of the
6.7 recipient, or in the event of a minor with parents not living together, the primary residences
6.8 of the parents;
6.9 (7) expenses for travel, lodging, or meals related to training the recipient, the
6.10 ~~parent or guardian of an adult recipient, or the parent or guardian of a minor child~~ legal
6.11 representative, or paid or unpaid caregivers that exceed $500 in a 12-month period;
6.12 (8) experimental treatment;
6.13 (9) any service or item to the extent the service or item is covered by other medical
6.14 assistance state plan services, including prescription and over-the-counter medications,
6.15 compounds, and solutions and related fees, including premiums and co-payments;
6.16 (10) membership dues or costs, except when the service is necessary and appropriate
6.17 to treat a physical condition or to improve or maintain the recipient's physical condition.
6.18 The condition must be identified in the recipient's plan of care and monitored by a
6.19 Minnesota health care program enrolled physician;
6.20 (11) vacation expenses other than the cost of direct services;
6.21 (12) vehicle maintenance or modifications not related to the disability;
6.22 (13) tickets and related costs to attend sporting or other recreational events that are
6.23 not related to a need or goal identified in the person-centered service plan; and
6.24 (14) costs related to Internet access, except when necessary for operation of assistive
6.25 technology, to increase independence, or to substitute for human assistance.
6.26 Subd. 8. **Self-directed budget requirements.** (a) The budget for the provision of
6.27 the self-directed service option shall be established for persons eligible for personal care
6.28 assistant services under section 256B.0659 based on:
6.29 (1) assessed personal care assistance units, not to exceed the maximum number of
6.30 personal care assistance units available, as determined by section 256B.0659; and
6.31 (2) the personal care assistance unit rate:
6.32 (i) with a reduction to the unit rate to pay for a program administrator as defined in
6.33 subdivision 10; and
6.34 (ii) an additional adjustment to the unit rate as needed to ensure cost neutrality for
6.35 the state.

7.1 (b) The budget for persons eligible for programs listed in subdivision 2, paragraph
7.2 (a), clause (2), is based on the approved budget methodologies for each program.
7.3 Subd. 9. **Quality assurance and risk management.** (a) The commissioner
7.4 shall establish quality assurance and risk management measures for use in developing
7.5 and implementing self-directed plans and budgets that (1) recognize the roles and
7.6 responsibilities involved in obtaining services in a self-directed manner, and (2) assure
7.7 the appropriateness of such plans and budgets based upon a recipient's resources and
7.8 capabilities. These measures must include (i) background studies, and (ii) backup and
7.9 emergency plans, including disaster planning.
7.10 (b) The commissioner shall provide ongoing technical assistance and resource
7.11 and educational materials for families and recipients selecting the self-directed option,
7.12 including information on the quality assurance efforts and activities of region 10 under
7.13 sections 256B.095 to 256B.096.
7.14 (c) Performance assessments measures, such as of a recipient's functioning,
7.15 satisfaction with the services and supports, and ongoing monitoring of health and
7.16 well-being shall be identified in consultation with the stakeholder group.
7.17 Subd. 10. **Fiscal support entity.** (a) Each recipient or legal representative shall
7.18 choose a fiscal support entity provider certified by the commissioner to make payments
7.19 for services, items, supports, and administrative costs related to managing a self-directed
7.20 service plan authorized for payment in the approved plan and budget. ~~Recipients~~ The
7.21 recipient or legal representative shall also choose the payroll, agency with choice, or the
7.22 fiscal conduit model of financial and service management.
7.23 (b) The fiscal support entity:
7.24 (1) may not limit or restrict the recipient's choice of service or support providers,
7.25 including use of the payroll, agency with choice, or fiscal conduit model of financial
7.26 and service management;
7.27 (2) must have a written agreement with the recipient, managing partner, or the
7.28 recipient's legal representative that identifies the duties and responsibilities to be
7.29 performed and the specific related charges;
7.30 (3) must provide the recipient ~~and the home care targeted case manager~~, legal
7.31 representative, and managing partner with a monthly written summary of the self-directed
7.32 supports option services that were billed, including charges from the fiscal support entity;
7.33 (4) must be knowledgeable of and comply with Internal Revenue Service
7.34 requirements necessary to process employer and employee deductions, provide appropriate
7.35 and timely submission of employer tax liabilities, and maintain documentation to support
7.36 medical assistance claims;

8.1 (5) must have current and adequate liability insurance and bonding and sufficient
8.2 cash flow and have on staff or under contract a certified public accountant or an individual
8.3 with a baccalaureate degree in accounting; and

8.4 (6) must maintain records to track all self-directed supports option services
8.5 expenditures, including time records of persons paid to provide supports and receipts for
8.6 any goods purchased. The records must be maintained for a minimum of five years from
8.7 the claim date and be available for audit or review upon request. Claims submitted by
8.8 the fiscal support entity must correspond with services, amounts, and time periods as
8.9 authorized in the recipient's self-directed supports option plan.

8.10 (c) The commissioner shall have authority to:

8.11 (1) set or negotiate rates with fiscal support entities;

8.12 (2) limit the number of fiscal support entities;

8.13 (3) identify a process to certify and recertify fiscal support entities and assure fiscal
8.14 support entities are available to recipients throughout the state; and

8.15 (4) establish a uniform format and protocol to be used by eligible fiscal support
8.16 entities.

8.17 Subd. 11. **Stakeholder consultation.** The commissioner shall consult with
8.18 a statewide ~~consumer-directed~~ self-directed services stakeholder group, including
8.19 representatives of all types of ~~consumer-directed~~ self-directed service users, advocacy
8.20 organizations, counties, and ~~consumer-directed~~ self-directed service providers. The
8.21 commissioner shall seek recommendations from this stakeholder group in developing,
8.22 monitoring, evaluating, and modifying:

8.23 (1) the self-directed plan format;

8.24 (2) requirements and guidelines for the person-centered plan assessment and
8.25 planning process;

8.26 (3) implementation of the option and the quality assurance and risk management
8.27 techniques; ~~and~~

8.28 (4) standards and requirements, including rates for the personal support plan
8.29 development provider and the fiscal support entity; policies; training; and implementation;
8.30 and

8.31 (5) the self-directed supports options available through the home and
8.32 community-based waivers under section 256B.0916 and the personal care assistance
8.33 program under section 256B.0659, including ways to increase participation, improve
8.34 flexibility, and include incentives for recipients to participate in a life transition and crisis
8.35 funding pool with others to save and contribute part of their authorized budgets, which

can be carried over year to year and used according to priority standards under section 256B.092, subdivision 12, clauses (1), (3), (4), (5), and (6).

The stakeholder group shall provide recommendations on the repeal of the personal care assistance choice option, transition issues, and whether the consumer support grant program under section 256.476 should be modified. The stakeholder group shall meet at least three times each year to provide advice on policy, implementation, and other aspects of ~~consumer and~~ self-directed services.

Subd. 12. **Enrollment and evaluation.** Enrollment in the self-directed supports option is available to current personal care assistance recipients upon annual personal care assistance reassessment, with a maximum enrollment of ~~1,000~~ 2,000 people in the first fiscal year of implementation and an additional ~~1,000~~ 3,000 people in the second fiscal year. The commissioner shall evaluate the self-directed supports option during the first two years of implementation and make any necessary changes ~~prior to the option becoming available statewide~~.

EFFECTIVE DATE. This section is effective July 1, 2012.

Sec. 3. Minnesota Statutes 2010, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Long-term care consultation services" means:

(1) assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations on cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) federally mandated screening to determine the need for an institutional level of care under subdivision 4a;

(7) determination of home and community-based waiver service eligibility including level of care determination for individuals who need an institutional level of care as defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan home care services identified in sections 256B.0625, subdivisions

10.1 6, 7, and 19, paragraphs (a) and (c), and 256B.0657, based on assessment and support
10.2 plan development with appropriate referrals, including the option for ~~consumer-directed~~
10.3 ~~community~~ self-directed supports;

10.4 (8) providing recommendations for nursing facility placement when there are no
10.5 cost-effective community services available; ~~and~~

10.6 (9) assistance to transition people back to community settings after facility
10.7 admission; and

10.8 (10) providing notice to the individual and legal representative of the annual and
10.9 monthly amount authorized for traditional agency services and self-directed services under
10.10 section 256B.0657 for which the recipient is found eligible.

10.11 (b) "Long-term care options counseling" means the services provided by the linkage
10.12 lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes
10.13 telephone assistance and follow up once a long-term care consultation assessment has
10.14 been completed.

10.15 (c) "Minnesota health care programs" means the medical assistance program under
10.16 chapter 256B and the alternative care program under section 256B.0913.

10.17 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
10.18 plans administering long-term care consultation assessment and support planning services.

10.19 **EFFECTIVE DATE.** This section is effective January 1, 2012.

10.20 Sec. 4. Minnesota Statutes 2010, section 256B.0911, subdivision 3a, is amended to
10.21 read:

10.22 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
10.23 services planning, or other assistance intended to support community-based living,
10.24 including persons who need assessment in order to determine waiver or alternative care
10.25 program eligibility, must be visited by a long-term care consultation team within 15
10.26 calendar days after the date on which an assessment was requested or recommended. After
10.27 January 1, 2011, these requirements also apply to personal care assistance services, private
10.28 duty nursing, and home health agency services, on timelines established in subdivision 5.
10.29 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

10.30 (b) The county may utilize a team of either the social worker or public health nurse,
10.31 or both. After January 1, 2011, lead agencies shall use certified assessors to conduct the
10.32 assessment in a face-to-face interview. The consultation team members must confer
10.33 regarding the most appropriate care for each individual screened or assessed.

10.34 (c) The assessment must be comprehensive and include a person-centered
10.35 assessment of the health, psychological, functional, environmental, and social needs of

11.1 referred individuals and provide information necessary to develop a support plan that
11.2 meets the consumers needs, using an assessment form provided by the commissioner.

11.3 (d) The assessment must be conducted in a face-to-face interview with the person
11.4 being assessed and the person's legal representative, as required by legally executed
11.5 documents, and other individuals as requested by the person, who can provide information
11.6 on the needs, strengths, and preferences of the person necessary to develop a support plan
11.7 that ensures the person's health and safety, but who is not a provider of service or has any
11.8 financial interest in the provision of services.

11.9 (e) The person, or the person's legal representative, must be provided with
11.10 written recommendations for community-based services, including ~~consumer-directed~~
11.11 self-directed options, or institutional care that include documentation that the most
11.12 cost-effective alternatives available were offered to the individual. For purposes of
11.13 this requirement, "cost-effective alternatives" means community services and living
11.14 arrangements that cost the same as or less than institutional care. For persons determined
11.15 eligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (9), the
11.16 community support plan must also include the estimated annual and monthly budget
11.17 amount for those services.

11.18 (f) If the person chooses to use community-based services, the person or the person's
11.19 legal representative must be provided with a written community support plan, regardless
11.20 of whether the individual is eligible for Minnesota health care programs. A person may
11.21 request assistance in identifying community supports without participating in a complete
11.22 assessment. Upon a request for assistance identifying community support, the person must
11.23 be transferred or referred to the services available under sections 256.975, subdivision 7,
11.24 and 256.01, subdivision 24, for telephone assistance and follow up.

11.25 (g) The person has the right to make the final decision between institutional
11.26 placement and community placement after the recommendations have been provided,
11.27 except as provided in subdivision 4a, paragraph (c).

11.28 (h) The team must give the person receiving assessment or support planning, or
11.29 the person's legal representative, materials, and forms supplied by the commissioner
11.30 containing the following information:

11.31 (1) the need for and purpose of preadmission screening if the person selects nursing
11.32 facility placement;

11.33 (2) the role of the long-term care consultation assessment and support planning in
11.34 waiver and alternative care program eligibility determination;

11.35 (3) information about Minnesota health care programs;

11.36 (4) the person's freedom to accept or reject the recommendations of the team;

12.1 (5) the person's right to confidentiality under the Minnesota Government Data
12.2 Practices Act, chapter 13;
12.3 (6) the long-term care consultant's decision regarding the person's need for
12.4 institutional level of care as determined under criteria established in section 144.0724,
12.5 subdivision 11, or 256B.092; and
12.6 (7) the person's right to appeal the decision regarding the need for nursing facility
12.7 level of care or the county's final decisions regarding public programs eligibility according
12.8 to section 256.045, subdivision 3.
12.9 (i) Face-to-face assessment completed as part of eligibility determination for
12.10 the alternative care, elderly waiver, community alternatives for disabled individuals,
12.11 community alternative care, and traumatic brain injury waiver programs under sections
12.12 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more
12.13 than 60 calendar days after the date of assessment. The effective eligibility start date
12.14 for these programs can never be prior to the date of assessment. If an assessment was
12.15 completed more than 60 days before the effective waiver or alternative care program
12.16 eligibility start date, assessment and support plan information must be updated in a
12.17 face-to-face visit and documented in the department's Medicaid Management Information
12.18 System (MMIS). The effective date of program eligibility in this case cannot be prior to
12.19 the date the updated assessment is completed.

12.20 **EFFECTIVE DATE.** This section is effective January 1, 2012.

12.21 Sec. 5. Minnesota Statutes 2010, section 256B.0916, subdivision 6a, is amended to
12.22 read:
12.23 Subd. 6a. **Statewide availability of ~~consumer-directed community~~ self-directed**
12.24 **support services.** (a) The commissioner shall submit to the federal Health Care Financing
12.25 Administration by August 1, 2001, an amendment to the home and community-based
12.26 waiver ~~for persons with developmental disabilities~~ under section 256B.092 and by April 1,
12.27 2005, for waivers under sections 256B.0915 and 256B.49, to make ~~consumer-directed~~
12.28 ~~community~~ self-directed support services available in every county of the state ~~by January~~
12.29 ~~1, 2002~~.
12.30 (b) Until the waiver amendment under section 18 of this act is effective, if a
12.31 county declines to meet the requirements for provision of ~~consumer-directed community~~
12.32 self-directed supports, the commissioner shall contract with another county, a group of
12.33 counties, or a private agency to plan for and administer ~~consumer-directed community~~
12.34 self-directed supports in that county.

13.1 (c) The state of Minnesota, county agencies, tribal governments, or administrative
13.2 entities under contract to participate in the implementation and administration of the home
13.3 and community-based waiver for persons with developmental disabilities, shall not be
13.4 liable for damages, injuries, or liabilities sustained through the purchase of support by the
13.5 individual, the individual's family, legal representative, or the authorized representative
13.6 with funds received through the ~~consumer-directed community~~ self-directed support
13.7 service under this section. Liabilities include but are not limited to: workers' compensation
13.8 liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment
13.9 Tax Act (FUTA).

13.10 **EFFECTIVE DATE.** This section is effective July 1, 2011.

13.11 Sec. 6. Minnesota Statutes 2010, section 256B.092, subdivision 1a, is amended to read:
13.12 Subd. 1a. **Case management ~~administration and~~ services.** (a) ~~The administrative~~
13.13 ~~functions of case management provided to or arranged for a person include:~~
13.14 ~~(1) review of eligibility for services;~~
13.15 ~~(2) screening;~~
13.16 ~~(3) intake;~~
13.17 ~~(4) diagnosis;~~
13.18 ~~(5) the review and authorization of services based upon an individualized service~~
13.19 ~~plan; and~~
13.20 ~~(6) responding to requests for conciliation conferences and appeals according to~~
13.21 ~~section 256.045 made by the person, the person's legal guardian or conservator, or the~~
13.22 ~~parent if the person is a minor~~ Case management services shall be provided by public or
13.23 private agencies that are enrolled as a medical assistance provider determined by the
13.24 commissioner to meet all of the requirements in the approved federal waiver plans. Case
13.25 management services cannot be provided to a recipient by a private agency that has
13.26 any financial interest in the provisions of any other services included in the recipient's
13.27 coordinated service and support plan.
13.28 (b) Case management ~~service activities provided to or arranged for a person include~~
13.29 services shall be provided to each recipient of home and community-based waiver
13.30 services and available to those eligible for case management under sections 256B.0621
13.31 and 256B.0924, subdivision 4, who choose this service. Case management services for an
13.32 eligible person include:
13.33 (1) development of the ~~individual~~ coordinated service and support plan;
13.34 (2) informing the individual or the individual's legal guardian or conservator, or
13.35 parent if the person is a minor, of service options;

14.1 (3) consulting with relevant medical experts or service providers;
14.2 (4) assisting the person in the identification of potential providers;
14.3 (5) assisting the person to access services;
14.4 (6) coordination of services, including coordinating with the person's health care
14.5 home or health coordinator, if coordination of long-term care or community supports and
14.6 health care is not provided by another service provider;
14.7 (7) evaluation and monitoring of the services identified in the plan including at least
14.8 one face-to-face visit with each person annually by the case manager; and
14.9 (8) ~~annual reviews of service plans and services provided~~ review and provide the
14.10 lead agency with recommendations for service authorization based upon the individual's
14.11 needs identified in the support plan within ten working days after receiving the community
14.12 support plan from the certified assessor under section 256B.0911.
14.13 (c) Case management ~~administration and~~ service activities that are provided to the
14.14 person with a developmental disability shall be provided directly by ~~county agencies or~~
14.15 ~~under contract~~ a public or private agency that is enrolled as a medical assistance provider
14.16 determined by the commissioner to meet all of the requirements in section 256B.0621,
14.17 subdivision 5, paragraphs (a) and (b), clauses (1) to (5), and have no financial interest in
14.18 the provision of any other services to the person choosing case management service.
14.19 (d) ~~Case managers are responsible for the administrative duties and service~~
14.20 ~~provisions listed in paragraphs (a) and (b).~~ Case managers shall collaborate with
14.21 consumers, families, legal representatives, and relevant medical experts and service
14.22 providers in the development and annual review of the individualized service and
14.23 habilitation plans.
14.24 (e) The Department of Human Services shall offer ongoing education in case
14.25 management to case managers. Case managers shall receive no less than ten hours of case
14.26 management education and disability-related training each year.
14.27 (f) For persons eligible for home and community-based waiver services under this
14.28 section, case management service must be provided and paid for under the terms of the
14.29 approved federal waiver plans and cannot be billed as targeted case management.
14.30 (g) Persons may choose a case management service provider from among the public
14.31 or private vendors enrolled according to paragraph (d).

14.32 **EFFECTIVE DATE.** This section is effective January 1, 2012.

14.33 Sec. 7. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to read:

15.1 Subd. 1b. **~~Individual~~ Coordinated service and support plan.** ~~The individual~~
15.2 Each recipient of case management service and any legal representative shall be provided
15.3 a written copy of the coordinated service and support plan ~~must~~, which:
15.4 (1) ~~include~~ is developed within ten working days after the case management service
15.5 receives the community support plan from the certified assessor under section 256B.0911;
15.6 (2) includes the results of the assessment information on the person's need for
15.7 service, including identification of service needs that will be or that are met by the person's
15.8 relatives, friends, and others, as well as community services used by the general public;
15.9 (3) reasonably assures the health, safety, and welfare of the recipient;
15.10 ~~(2) identify~~ (4) identifies the person's preferences for services as stated by the person,
15.11 the person's legal guardian or conservator, or the parent if the person is a minor;
15.12 (5) provides for an informed choice, as defined in section 256B.77, subdivision 2,
15.13 paragraph (o), of service and support providers;
15.14 ~~(3) identify~~ (6) identifies long- and short-range goals for the person;
15.15 ~~(4) identify~~ (7) identifies specific services and the amount and frequency of the
15.16 services to be provided to the person based on assessed needs, preferences, and available
15.17 resources. The ~~individual~~ coordinated service and support plan shall also specify other
15.18 services the person needs that are not available;
15.19 ~~(5) identify~~ (8) identifies the need for an ~~individual program~~ individual's provider
15.20 plan to be developed by the provider according to the respective state and federal licensing
15.21 and certification standards, and additional assessments to be completed or arranged by the
15.22 provider after service initiation;
15.23 ~~(6) identify~~ (9) identifies provider responsibilities to implement and make
15.24 recommendations for modification to the ~~individual~~ coordinated service and support plan;
15.25 ~~(7) include~~ (10) includes notice of the right to have assessments completed and
15.26 service plans developed within specified time periods, the right to appeal action or
15.27 inaction, and the right to request ~~a conciliation conference or a hearing~~ an appeal under
15.28 section 256.045;
15.29 ~~(8) be~~ (11) is agreed upon and signed by the person, the person's legal guardian
15.30 or conservator, or the parent if the person is a minor, and the authorized county
15.31 representative; and
15.32 ~~(9) be~~ (12) is reviewed by a health professional if the person has overriding medical
15.33 needs that impact the delivery of services.
15.34 ~~Service planning formats developed for interagency planning such as transition,~~
15.35 ~~vocational, and individual family service plans may be substituted for service planning~~
15.36 ~~formats developed by county agencies.~~

EFFECTIVE DATE. This section is effective January 1, 2012.

Sec. 8. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to read:

Subd. 1e. **Case management service monitoring, coordination, and evaluation~~,~~ ~~and monitoring of services~~ duties.** (a) If the ~~individual~~ coordinated service and support plan identifies the need for individual ~~program~~ provider plans for authorized services, the case ~~manager~~ management service provider shall assure that ~~individual program~~ the individual provider plans are developed by the providers according to clauses (2) to (5). The providers shall assure that the individual ~~program~~ provider plans:

(1) are developed according to the respective state and federal licensing and certification requirements;

(2) are designed to achieve the goals of the individual service plan;

(3) are consistent with other aspects of the ~~individual~~ coordinated service and support plan;

(4) assure the health and safety of the person; and

(5) are developed with consistent and coordinated approaches to services among the various service providers.

(b) The case ~~manager~~ management service provider shall monitor the provision of services:

(1) to assure that the individual service plan is being followed according to paragraph (a);

(2) to identify any changes or modifications that might be needed in the individual service plan, including changes resulting from recommendations of current service providers;

(3) to determine if the person's legal rights are protected, and if not, notify the person's legal guardian or conservator, or the parent if the person is a minor, protection services, or licensing agencies as appropriate; and

(4) to determine if the person, the person's legal guardian or conservator, or the parent if the person is a minor, is satisfied with the services provided.

(c) If the provider fails to develop or carry out the individual program plan according to paragraph (a), the case manager shall notify the person's legal guardian or conservator, or the parent if the person is a minor, the provider, the respective licensing and certification agencies, and the county board where the services are being provided. In addition, the case manager shall identify other steps needed to assure the person receives the services identified in the ~~individual~~ coordinated service and support plan.

EFFECTIVE DATE. This section is effective January 1, 2012.

17.1 Sec. 9. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to read:
17.2 Subd. 1g. **Conditions not requiring development of ~~individual~~ a coordinated**
17.3 **service and support plan.** Unless otherwise required by federal law, the county agency is
17.4 not required to complete ~~an individual~~ a coordinated service and support plan as defined in
17.5 subdivision 1b for:
17.6 (1) persons whose families are requesting respite care for their family member who
17.7 resides with them, or whose families are requesting a family support grant and are not
17.8 requesting purchase or arrangement of habilitative services; and
17.9 (2) persons with developmental disabilities, living independently without authorized
17.10 services or receiving funding for services at a rehabilitation facility as defined in section
17.11 268A.01, subdivision 6, and not in need of or requesting additional services.

17.12 **EFFECTIVE DATE.** This section is effective January 1, 2012.

17.13 Sec. 10. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:
17.14 Subd. 3. **Authorization and termination of services.** ~~County agency case~~
17.15 ~~managers~~ Lead agencies, under rules of the commissioner, shall authorize and terminate
17.16 services of community and regional treatment center providers according to ~~individual~~
17.17 coordinated service and support plans. Services provided to persons with developmental
17.18 disabilities may only be authorized and terminated ~~by case managers~~ according to (1)
17.19 rules of the commissioner and (2) the ~~individual~~ coordinated service and support plan as
17.20 defined in subdivision 1b. Medical assistance services not needed shall not be authorized
17.21 by county agencies or funded by the commissioner. When purchasing or arranging for
17.22 unlicensed respite care services for persons with overriding health needs, the county
17.23 agency shall seek the advice of a health care professional in assessing provider staff
17.24 training needs and skills necessary to meet the medical needs of the person.

17.25 **EFFECTIVE DATE.** This section is effective January 1, 2012.

17.26 Sec. 11. Minnesota Statutes 2010, section 256B.092, subdivision 8, is amended to read:
17.27 Subd. 8. ~~**Screening team**~~ **Additional certified assessor duties.** The ~~screening team~~
17.28 certified assessor shall:
17.29 (1) review diagnostic data;
17.30 (2) review health, social, and developmental assessment data using a ~~uniform~~
17.31 ~~screening~~ comprehensive assessment tool specified by the commissioner;
17.32 (3) identify the level of services appropriate to maintain the person in the most
17.33 normal and least restrictive setting that is consistent with the person's treatment needs;

18.1 (4) identify other noninstitutional public assistance or social service that may prevent
18.2 or delay long-term residential placement;
18.3 (5) assess whether a person is in need of long-term residential care;
18.4 (6) make recommendations regarding ~~placement~~ <u>services</u> and payment for: (i) social
18.5 service or public assistance support, or both, to maintain a person in the person's own home
18.6 or other place of residence; (ii) training and habilitation service, vocational rehabilitation,
18.7 and employment training activities; (iii) community residential ~~placement~~ <u>services</u>; ~~(iv)~~
18.8 ~~regional treatment center placement;~~ or ~~(v)~~ <u>(iv)</u> a home and community-based service
18.9 alternative to community residential placement or regional treatment center placement;
18.10 (7) evaluate the availability, location, and quality of the services listed in clause
18.11 (6), including the impact of ~~placement alternatives~~ <u>services and supports options</u> on the
18.12 person's ability to maintain or improve existing patterns of contact and involvement with
18.13 parents and other family members;
18.14 (8) identify the cost implications of recommendations in clause (6) <u>and provide</u>
18.15 <u>written notice of the annual and monthly amount authorized to be spent for services for</u>
18.16 <u>the recipient</u>;
18.17 (9) make recommendations to a court as may be needed to assist the court in making
18.18 decisions regarding commitment of persons with developmental disabilities; and
18.19 (10) inform the person and the person's legal guardian or conservator, or the parent if
18.20 the person is a minor, that appeal may be made to the commissioner pursuant to section
18.21 256.045.

18.22 <u>**EFFECTIVE DATE.**</u> <u>This section is effective January 1, 2012.</u>

18.23 Sec. 12. Minnesota Statutes 2010, section 256B.092, subdivision 8a, is amended to
18.24 read:
18.25 Subd. 8a. **County ~~concurrence~~ <u>notification</u>.** (a) If the county of financial
18.26 responsibility wishes to place a person in another county for services, the county of
18.27 financial responsibility shall ~~seek concurrence from~~ <u>notify</u> the proposed county of service
18.28 and the placement shall be made cooperatively between the two counties. Arrangements
18.29 shall be made between the two counties for ongoing social service, including annual
18.30 reviews of the person's individual service plan. The county where services are provided
18.31 may not make changes in the person's service plan without approval by the county of
18.32 financial responsibility.
18.33 (b) ~~When a person has been screened and authorized for services in an intermediate~~
18.34 ~~care facility for persons with developmental disabilities or for home and community-based~~
18.35 ~~services for persons with developmental disabilities, the case manager shall assist that~~

19.1 ~~person in identifying a service provider who is able to meet the needs of the person~~
19.2 ~~according to the person's individual service plan. If the identified service is to be provided~~
19.3 ~~in a county other than the county of financial responsibility, the county of financial~~
19.4 ~~responsibility shall request concurrence of the county where the person is requesting to~~
19.5 ~~receive the identified services.~~ The county of service ~~may refuse to concur~~ shall notify
19.6 the county of financial responsibility if~~:~~,

19.7 ~~(1) it can demonstrate that the provider is unable to provide the services identified in~~
19.8 ~~the person's individual service plan as services that are needed and are to be provided; or~~

19.9 ~~(2)~~ in the case of an intermediate care facility for persons with developmental
19.10 disabilities, there has been no authorization for admission by the admission review team
19.11 as required in section 256B.0926.

19.12 (c) The county of service shall notify the county of financial responsibility of
19.13 ~~concurrence or refusal to concur~~ any concerns about the chosen provider's capacity to
19.14 meet the needs of the person seeking to move to residential services in another county no
19.15 later than 20 working days following receipt of the written ~~request~~ notification. Unless
19.16 other mutually acceptable arrangements are made by the involved county agencies, the
19.17 county of financial responsibility is responsible for costs of social services and the costs
19.18 associated with the development and maintenance of the placement. The county of
19.19 service may request that the county of financial responsibility purchase case management
19.20 services from the county of service or from a contracted provider of case management
19.21 when the county of financial responsibility is not providing case management as defined
19.22 in this section and rules adopted under this section, unless other mutually acceptable
19.23 arrangements are made by the involved county agencies. Standards for payment limits
19.24 under this section may be established by the commissioner. Financial disputes between
19.25 counties shall be resolved as provided in section 256G.09.

19.26 **EFFECTIVE DATE.** This section is effective July 1, 2011.

19.27 Sec. 13. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

19.28 Subd. 13. **Case management.** ~~(a)~~ Each recipient of a home and community-based
19.29 waiver under this section shall be provided case management services according to
19.30 section 256B.092, subdivisions 1a, 1b, and 1e, by qualified vendors as described in the
19.31 federally approved waiver application. ~~The case management service activities provided~~
19.32 ~~will include:~~

19.33 ~~(1) assessing the needs of the individual within 20 working days of a recipient's~~
19.34 ~~request;~~

~~(2) developing the written individual service plan within ten working days after the assessment is completed;~~

~~(3) informing the recipient or the recipient's legal guardian or conservator of service options;~~

~~(4) assisting the recipient in the identification of potential service providers;~~

~~(5) assisting the recipient to access services;~~

~~(6) coordinating, evaluating, and monitoring of the services identified in the service plan;~~

~~(7) completing the annual reviews of the service plan; and~~

~~(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3, including the determination of nursing facility level of care.~~

~~(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.~~

EFFECTIVE DATE. This section is effective January 1, 2012.

Sec. 14. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request as provided in section 256B.0911. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Persons with developmental disabilities who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.

(e) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

EFFECTIVE DATE. This section is effective January 1, 2012.

Sec. 15. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **~~Individualized~~ Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan ~~which:~~ that complies with the requirements of section 256B.092, subdivision 1b.

~~(1) is developed and signed by the recipient within ten working days of the completion of the assessment;~~

~~(2) meets the assessed needs of the recipient;~~

~~(3) reasonably ensures the health and safety of the recipient;~~

~~(4) promotes independence;~~

~~(5) allows for services to be provided in the most integrated settings; and~~

~~(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers.~~

(b) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

EFFECTIVE DATE. This section is effective January 1, 2012.

Sec. 16. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **Excluded time.** "Excluded time" means:

(a) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, semi-independent living domicile or services program, residential facility offering care, board and lodging facility

22.1 or other institution for the hospitalization or care of human beings, as defined in section
22.2 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter,
22.3 or correctional facility; or any facility based on an emergency hold under sections
22.4 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

22.5 (b) any period an applicant spends on a placement basis in a training and habilitation
22.6 program, including a rehabilitation facility or work or employment program as defined
22.7 in section 268A.01; ~~or receiving personal care assistance services pursuant to section~~
22.8 ~~256B.0659;~~ semi-independent living services provided under section 252.275, and
22.9 Minnesota Rules, parts 9525.0500 to 9525.0660; day training and habilitation programs
22.10 and assisted living services; and

22.11 (c) any placement for a person with an indeterminate commitment, including
22.12 independent living.

22.13 **EFFECTIVE DATE.** This section is effective July 1, 2011.

22.14 Sec. 17. **STATE PLAN AMENDMENT TO IMPLEMENT SELF-DIRECTED**
22.15 **PERSONAL SUPPORTS.**

22.16 By July 15, 2011, the commissioner shall submit a state plan amendment to
22.17 implement Minnesota Statutes, section 256B.0657, as soon as possible upon federal
22.18 approval.

22.19 Sec. 18. **AMENDMENT FOR SELF-DIRECTED COMMUNITY SUPPORTS.**

22.20 By September 1, 2011, the commissioner shall submit an amendment to the home
22.21 and community-based waiver programs consistent with implementing the self-directed
22.22 option under Minnesota Statutes, section 256B.0657, through statewide enrolled providers
22.23 contracted to provide outreach information, training, and fiscal support entity services to
22.24 all eligible recipients choosing this option and with shared care in some types of services.
22.25 The waiver amendment shall be consistent with changes in case management service
22.26 under Minnesota Statutes, section 256B.092.

22.27 Sec. 19. **ESTABLISHMENT OF RATES FOR SHARED HOME AND**
22.28 **COMMUNITY-BASED WAIVER ADMINISTRATIVE SERVICES.**

22.29 By January 1, 2012, the commissioner shall establish rates to be paid for in-home
22.30 services and personal supports under all of the home and community-based waiver
22.31 services programs consistent with the standards in Minnesota Statutes, section 256B.4912,
22.32 subdivision 2.

23.1 Sec. 20. **ESTABLISHMENT OF RATES FOR CASE MANAGEMENT**
23.2 **SERVICES.**

23.3 By January 1, 2012, the commissioner shall establish the rate to be paid for
23.4 case management services under Minnesota Statutes, sections 256B.092 and 256B.49,
23.5 consistent with the standards in Minnesota Statutes, section 256B.4912, subdivision 2.

23.6 Sec. 21. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT**
23.7 **REDESIGN.**

23.8 By February 1, 2012, the commissioner of human services shall develop a legislative
23.9 report with specific recommendations and language for proposed legislation to be effective
23.10 July 1, 2012, for the following:

23.11 (1) definitions of service and consolidation of standards and rates to the extent
23.12 appropriate for all types of medical assistance case management services, including
23.13 targeted case management under Minnesota Statutes, sections 256B.0621; 256B.0625,
23.14 subdivision 20; and 256B.0924; mental health case management services for children
23.15 and adults, all types of home and community-based waiver case management, and case
23.16 management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work shall be
23.17 completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

23.18 (2) recommendations on county of financial responsibility requirements and quality
23.19 assurance measures for case management; and

23.20 (3) identification of county administrative functions that may remain entwined in
23.21 case management service delivery models.