Delaware Developmental Disabilities Council
Margaret M. O'Neill Building, 2nd Floor
410 Federal Street - Suite 2 Dover, Delaware 19901
Phone: 302.739.3333 ♦ Fax: 302.739.2015 ♦ Website: www.ddc.delaware.gov

MEMORANDUM

DATE: March 12, 2014

TO: Ms. Rita Landgraf, Cabinet Secretary
Mr. Stephen Groff, DMMA Director
Mrs. Jane Gallivan, DDDS Director
Mr. Daniel Chappell, DMMA Social Services Administrator
Ms. Eddi Ashby, DDDS HCBS Waiver Manager

FROM: Diann Jones, Chairperson
Developmental Disabilities Council

RE: DDDS HCBS Waiver Application

The Developmental Disabilities Council (DDC) has reviewed the Department of Health and Social Services/Division of Developmental Disabilities Services' (DDDS) application to CMS for a §1915(c) Home and Community-Based Services Waiver.

On February 28, 2014, the Division of Developmental Disabilities Services forwarded a notice to the DD Council and other agencies that its draft waiver renewal was available for review on its website. We are providing the following analysis of the document. Given time constraints, this critique should be considered preliminary and non-exhaustive. Parenthetically, since the notice recites that DDDS intends to submit its application to CMS "not later than the end of the week of March 10th", the DD Council is sending these comments for consideration.

1. Preliminarily, the Council would like to express concern with the truncated opportunity for comment. The "Public Input" section (p. 8) recites that DDDS will publish notice of the renewal in the Register of Regulations and establish a 30-day comment period. In contrast, no notice has appeared in the Register of Regulations and the February 28 notice emailed to the DD Council offers only a 2-week comment period since DDDS plans to submit its application during the week of March 10. In practice, DHSS submits its proposed waivers to the Register with at least a 30-day comment period. Compare 17 Del. Reg. 156 (August 1, 2013); 17 DE Reg 688 (January 1, 2014); and 17 DE Reg. 930 (March 1, 2014).

2. Delaware DHSS has included participant direction into its recent waiver initiatives, including personal care/attendant services in both the "Pathways to Employment" waiver [17 DE Reg. 688 (January 1, 2014) and the Diamond State Health Plan Plus waiver [16 DE Reg. 1140 (May 1, 2013)]. CMS explicitly encourages states to include participant direction in their waivers:

> CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making

> authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

At 91. The first explicit objective for the DDDS waiver is to "(p)romote independence for individuals enrolled in the waiver...". At 4.

In contrast, DHSS certifies (p. 90) that "(t)his waiver does not provide participant direction opportunities." This rejection of participant direction opportunities is reiterated throughout the document. See, e.g., pp. 5, 41, and 43.

The rejection of participant direction opportunities is an anachronism.

3. The DDDS eligibility regulation [16 DE Admin Code 2100] includes individuals with brain injury. In contrast, the waiver contains zero (0) references to brain injury. It explicitly covers (p. 20) persons with intellectual developmental disability, autism spectrum disorder, and Prader Willi Syndrome. This may be cause for alarm, particularly among proponents of services for individuals with brain injury who are being manifestly omitted from waiver coverage.

4. DDDS proposes (p. 20) no upper or maximum age limit for participants. However, although the current waiver covers children ages 4 and up, DDDS proposes (pp. 1 and 20) to restrict eligibility to children age 12 and older. This is objectionable and short-sighted for several reasons.

A. Historically, DDDS has offered shared living/foster care for children with families with special interest and expertise in caring for individuals with developmental disabilities. If approved, DDDS could no longer pay for this service on behalf of children under age 12 with the federally subsidized waiver funds.

B. The attached DDDS enabling statute [Title 29 Del.C. §7909A] imposes a "duty" to provide "foster care placements", "neighborhood homes", and "supported living" without any exclusions based on age. In the absence of a statutory authorization to discriminate based on age, DDDS cannot limit its services to certain age groups without violating the Age Discrimination Act and its implementing regulations. When the Division adopted a policy of excluding minors from its group home system in the past, it was "prompted" to settle an HHS OCR complaint by rescinding the policy. See attachments. Cf. attached OCR directive to Division of Public Health that presumptive age limit for nursing home admission violates Age Discrimination Act and attached DSAAPD letter to DFS successfully challenging age limit on foster parents based on Age Discrimination Act. If CMS approves the age restriction in the waiver, DDDS will still have to provide residential and other waiver services to children under age 12. It will simply have to do so with no federal Medicaid match.

C. The DDDS enabling statute [§7909(c)(4)] requires DDDS to provide early intervention services to children ages 0-3. Early intervention services under the DHSS implementation of IDEA-Part C include a lengthy list of supports and services. See, e.g. Title 16 Del.C. §212. Moreover, some children with developmental disabilities are eligible for IDEA-Part B at birth. The Interagency Collaborative Team (ICT) [Title 14 Del.C. §3124] could prompt DDDS to provide residential programming to such children. If the children are ineligible for the waiver based on age,

DDDS will have to provide residential services solely with state funds.

D. In the past, DDDS investigated systemic neglect of young children with developmental disabilities in a nursing facility (Harbor Health). See attached News Journal articles. The availability of waiver-funded residential options on an emergency basis would be an important resource if such a situation recurred. If the Division "ties its hands" by excluding pre-teens from the waiver, it loses capacity to address this type of situation.

5. Although the waiver document (p. 69) generally suggests that the "State does not impose a limit on the amount of waiver services", the State imposes (pp. 55-56) an absolute weekly cap of forty (40) hours on supported living. The effect will be "creaming", i.e., only individuals with modest to mild needs will be able to live in supported apartments or their own homes since support services are capped. Perhaps this is why DDDS projects 825 waiver participants in group homes and only 30 participants in supported living in the first year of implementation. See pp. 148-149. The absolute cap on supported living undermines "choice" and the recently published CMS policy preference for provision of waiver services in integrated settings [79 Fed. Reg. 2948 (January 16, 2014)]. The revised CMS regulation [42 C.F.R. 441.745; 79 Fed Reg at 3038] recites that "a State may not limit access to services based upon....the cost of services."

6. The waiver document recites that shared living providers offer residential habilitation services and "are paid at the Medicaid rate for the hours of support they provide up to a maximum of the support hours indicated by the member's ICAP score." At p. 139. It is unclear if there is an absolute cap on payment under the ICAP system. If there is a cap, this may limit "choice" and the ability of high-need individuals to avoid institutional placement.

7. The waiver document (p. 59) contains the following description of neighborhood group homes: "Each resident must have their own bedroom unless they express a preference to share a room". This is of questionable accuracy. The DDDS neighborhood regulation [16 DE Admin Code 3310, §8.0] does not contain such a standard. Parenthetically, private rooms must be an available option in waivers based on a participant's choice. See 79 Fed Reg at 2964.

8. The waiver document authorizes relatives to serve as providers of both "shared living" and "supported living" services. See pp. 2, 55-56 and 61. The CMS templates allows the State to authorize "guardians" to serve as providers as well. Id. However, DHSS has rejected this option. Id. This is unfortunate for several reasons.

A. Other DHSS programs do not bar provision of services by guardians. DDDS has suggested that, in the common situation in which parents are co-guardians of an adult child, a Chancery Court petition could be filed to remove one parent as guardian so the "removed" parent could qualify as a waiver service provider. This is a rather byzantine approach.

B. DDDS has experienced great difficulty in promoting relatives to petition for guardianship when necessary. The exclusion of guardians from serving as waiver providers will simply provide an additional disincentive to relatives considering pursuit of guardianship.

C. One of the purposes of the waiver is to "promote the engagement of family ...supports

whenever possible." At p. 4. This objective is undermined by the ban on guardian providers.

9. It is our belief that DDDS has approved a parent to serve as a prevocational service provider. The waiver document would apparently disallow any relative from serving as a prevocational provider since the "check-off" for relatives is blank. See p. 43. Likewise, a relative could not provide individual supported employment. See p. 49.

10. The qualifications for a DDDS case manager are "meager". See p. 70. A high school diploma is not even necessary.

11. Although there is one outlier reference to diversion from a nursing facility, the waiver generally adopts an ICF/IID level of care standard. See pp. 3, 20, 31, and 147. Since some waiver participants could lack an intellectual disability (e.g. DDDS autism eligibility regulation does not require intellectual deficit), the State could consider multiple level of care settings for inclusion in the waiver. For example, the attached December, 2013 DDDS census report lists 37 DDDS clients in nursing homes.

12. The waiver document contains multiple recitals that the waiver will limit services to participants to those "not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA)...". See pp. 7, 47, and 49. This may contravene federal law. See attachments. See also 34 C.F.R. §303.222.

13. The section on restraints (pp. 100 and 103) is not entirely accurate. It recites that the sole standard applied by providers is "Mandt" protocols which limit personal restraints to "the one and two person side body hug and the one and two arm supporting technique." In practice, DDDS has recently authorized some providers (e.g. AdvoServ) to use non-Mandt approved "supine" restraint.

14. The description of case manager activities in connection with ELP development (pp. 71-72) appeasr to be either inflated or hortatory. The document describes robust pre-planning activities beginning months prior to the actual ELP meeting.

15. The waiver previously included reporting to CMS on the offer of choice between institutional and waiver services. DDDS proposes to delete the reporting while continuing to "track" data. See pp. 2 and 6. This is unfortunate since the election is "key" to a central purpose of the waiver, i.e., to divert individuals from institutions. It would be preferable to maintain data reporting to CMS in this context.

16. CMS requires the State to project the number of participants in the waiver. See 42 C.F.R. 441.745 amended by 79 Fed Reg. 2948, 3038 (January 16, 2014). The reported authorized number of participants in the waiver may be too low. In year 1, DDDS envisions 1,000 participants. See pp. 22-23 and 147. We assume this covers the period from July 1, 2014 to June 30, 2015. In contrast, the attached DDDS December, 2013 monthly census report lists 992 clients already receiving community-based residential services. I suspect this number will exceed 1,000 prior to the inception of the waiver.

17. The waiver contains "quality" measures which focus on "safety" and absence of abuse/neglect.

See pp. 112-119. The waiver would benefit from some measures assessing satisfaction with services and quality of life.

18. DHSS may need to amend its HCBS waiver standards to include safeguards related to leases and protection from eviction. See 42 C.F.R. §441.530 [revised by 79 Fed. Reg. 3032 (January 16, 2014)] and commentary at 79 Fed Reg 2960-61.

19. The waiver document (p. 25) contains a countable income cap of 250% of the SSI Federal Benefit Rate (FBR). The State could have elected a "300%" standard. The Council may wish to encourage adoption of the higher benchmark.

Thank you for your consideration and please contact the Developmental Disabilities Council should you have any questions or comments regarding our position on the proposed regulation.

cc: The Honorable Melanie Smith
The Honorable Debra Heffernan
Ms. Marie Nonnenmacher
Ms. Chris Long
Mr. Brian Hartman, Esq.
Mr. Terry Olson, The Arc of Delaware
Mr. Brian Posey, AARP
Ms. Teresa Avery, Autism Delaware
Ms. Sharon Lyons, BIAD
Governor's Advisory Council for Exceptional Citizens
State Council for Persons with Disabilities

§ 7909A Division of Developmental Disabilities Services.

(a) There is hereby established the Division of Developmental Disabilities Services under the direction and control of the Secretary of the Department of Health and Social Services.

(b) The mission of the Division of Developmental Disabilities Services is to provide services and supports to individuals with developmental disabilities and their families which enable them to make informed choices that lead to an improved quality of life and meaningful participation in their communities.

(c) The Division of Developmental Disabilities Services shall have the following powers and duties:

(1) Provide community-based services including family supports, advocacy, foster care placements, respite, neighborhood homes, supported living, vocational and supported employment opportunities and day habilitation services;

(2) Provide case management, nursing, behavioral services, therapy and other professional supports needed to assist individuals in achieving their goal(s);

(3) Provide early intervention services to families so as to prevent or minimize developmental delays in children at risk who are ages 0-3; and

(4) Provide intermediate care facility residential services.

(d) The Division of Developmental Disabilities Services shall ensure the investigation of complaints of abuse, neglect, mistreatment and financial exploitation. Such investigations may be in coordination with the Attorney General's Office, law enforcement or other appropriate agencies.

(e) The Division of Developmental Disabilities Services shall be authorized to promulgate rules and regulations to implement this statute.

60 Del. Laws, c. 677, § 2; 73 Del. Laws, c. 97, § 6[5]; 78 Del. Laws, c. 179, § 315.;

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA

OFFICE OF THE SECRETARY
OFFICE FOR CIVIL RIGHTS
MAILING ADDRESS:
P.O. BOX 13716
PHILADELPHIA
PENNSYLVANIA 19101

Our Reference: 03863006

DEC 02 1986

Mr. Brian J. Hartman
Disabilities Law Program
Community Legal Aid Society, Inc.
913 Washington Street
Wilmington, Delaware 19801

Dear Mr. Hartman:

On November 24, 1986, we received your request to withdraw your complaint against the Department of Health and Social Services (DHS). Specifically, your complaint related to group-home services for mentally retarded persons under age eighteen under the authority of the Age Discrimination Act of 1975 and its implementing Regulation, 45 CFR Part 91.

It is our understanding that the assurances outlined in the agency's November 12, 1986 letter to you, satisfactorily resolve the issues relating to the complaint. The agency has provided its policy of non-discrimination on the basis of age and its assurance that it does not exclude the participation of persons under age eighteen in its group-home services. In addition, the agency will provide you with periodic reports, within the next year, regarding its clients under age eighteen.

We have informed DHS that our office will require copies of all periodic reports sent to you. These submissions will be due to us at the same time as they are sent to you. We have also advised the agency that if the information indicates disparity in the age of the clients served, we may re-open your complaint for a formal investigation.

We do appreciate your efforts in resolving this complaint informally and we are hopeful that the agency will continue to be cooperative in adhering to their assurances. If you have any questions, please contact Ms. Barbara Banks, Director, Investigations Division, at (215) 596-6173.

Sincerely yours,

Paul F. Cushing

Paul F. Cushing
Regional Manager

STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MENTAL RETARDATION
802 SILVER LAKE BOULEVARD
ROBBINS BUILDING
DOVER, DELAWARE 19901

OFFICE OF THE
DIRECTOR

TELEPHONE: (302) 736 - 4386

November 12, 1986

Brian J. Hartman, Esquire
Community Legal Aid Society, Inc.
913 Washington Street
Wilmington, DE 19801

Re: Residential Services for Mentally Retarded Minors

Dear Brian:

This is to confirm that the Department of Health and Social Services, Division of Mental Retardation (DMR) does not now, nor has it, violated 45 C.F.R. Part 90 in DMR's provision of community-based residential services.

Enclosed is a copy of a memorandum circulated to the Intake Committee at DMR, dated September 19, 1986. This memorandum confirms our policy of nondiscrimination.

The DMR Intake Committee will actively consider [illegible] for placement in a group home setting consistent with his nee[illegible] DMR is not compelled by this letter, however, to determine that [illegible] is an appropriate candidate for admission to a group home.

[illegible] will continue to be actively considered as one of a group of priority candidates for a community placement commensurate with [illegible]s needs.

Within one month of the date of this letter, DMR will forward to you the following non-identifying information: the total number of non-adults presently in DMR ICF/MR and neighborhood group home settings, specifying dates of birth and identity of group home in which each such non-adult resides.

Finally, within six months and one year from the provision of the above data, DMR will forward to you the following non-identifying information:

a. the total number of non-adults applying for placement in DMR ICF/MR and neighborhood group homes within the preceding six months, specifying dates of birth and action taken on each application;

b. the total number of non-adults in DMR ICF/MR and neighborhood group homes as of the respective dates, specifying dates of birth and identity of group home in which each such non-adult resides.

The terms of this letter are conditional upon your withdrawing the complaint in this matter.

Should there be material noncompliance with the representations in this letter, DMR understands that the complaint may be reopened until August 24, 1988, and that DMR waives its right to have such complaint heard in the first instance at the federal mediator level.

Very truly yours,

Thomas Pledgie

Thomas Pledgie, Ph.D.
Director, Division of Mental Retardation

TP:bwr

Enclosure

Susan Kirk-Ryan
Paul Cushing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA

OCT 18 1985
Office of Health Facili
Licensing and Certifica
OFFICE OF THE SECRET

OFFICE FOR CIVIL RIGH
MAILING ADDRESS:
P.O. BOX 13716
PHILADELPHIA
PENNSYLVANIA 19101

OCT 11 19

Mr. James E. Harvey
Director
Delaware Department of Health and
Social Services
Division of Public Health
Office of Health Facilities Licensing
and Certification
3000 Newport Gap Pike
Wilmington, Delaware 19808

Dear Mr. Harvey:

The Office for Civil Rights has completed its review of Delaware's Nursing Home Regulations for Skilled Care. Our analysis of the State's Regulations and determination regarding the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973 are as follows:

Section 57.3 - General Requirements

57.3 - An institution shall not admit any person under the age of fifteen (15) years of age as a patient unless approved by the State Board of Health.

Analysis

The Age Discrimination Act of 1975 and its implementing Regulation at 45 CFR Part 91, Subpart B Section 91.11(a) states that "No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance". Further, Section 91.11(b)(1) and (2) prohibits a recipient from using age distinctions which have the effect, on the basis of age, of excluding individuals from, or denying them the benefits of, or subjecting them to discrimination, under a program or activity receiving Federal financial assistance; denying or limiting individuals in their opportunity to participate in any Federally assisted program.

A recipient is permitted to take an action prohibited by Section 91.11 only if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity.

Determination

It is our preliminary determination that Section 57.3 of the State's Regulations violates the Age Discrimination Act of 1975 and 45 CFR Part 91 Subpart B Section 91.11.

Unless the State Agency can show that its age distinction is necessary to the normal operation of a nursing home or the achievement of a statutory objective, the age distinction must be removed. Please refer to 45 CFR Sections 91.13, 91.14 and 91.15.

It is my understanding that the State Board of Health may, on a case-by-case basis, consider an application for admission to a nursing home from someone under the age of fifteen. However, if the applicant's age and not the medical condition is the reason for this case-by-case review, then it is probable that this action violates the Age Discrimination Act.

Remedy

If your age distinction does not meet the criteria set forth at 45 CFR Sections 91.13 and 91.14, you may voluntarily resolve this deficiency by deleting from your Nursing Home Regulations any reference to an age criterion. You may also notify the public as well as all skilled care nursing facilities of this change in policy.

Section 57.8 - Services to Patients

57.809 Mental Illness
A. Patients who are, or become, mentally ill and who may be harmful to themselves or others, shall not be admitted or retained in a nursing home.

Analysis

Section 504 of the Rehabilitation Act of 1973 and its implementing Regulation 45 CFR Part 84 prohibit discrimination on the basis of handicap in any program or activity receiving Federal financial assistance. Section 84.3 of 45 CFR defines a handicapped person as one who (1) has a physical or mental impairment which substantially limits one or more major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment.

Specifically 45 CFR Section 84.4 provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

The State Agency may not, solely by reason of the presence or history of handicapping condition (mental illness), deny admission to a nursing home. For purpose of admission to a nursing home, a facility must admit one who is a qualified handicapped person, i.e., meets the essential eligibility criteria and requires the same type of medical or related services that are normally provided. Thus, Section 504 prohibits recipients from categorically excluding persons with mental impairments, as is specified in the State's Regulations at 57.809.

However, a recipient may take into account the behavioral manifestations of the mental impairment in determining whether one is a qualified handicapped individual. If the manifestations are such that the person no longer meets the basic eligibility requirements for the receipt of services or cause substantial interference with the operation of the program (be harmful to self or others), the condition may be taken into consideration.

Conditions such as Alzheimers Disease may be considered a mental impairment under the definition of handicapping condition; however the presence of this condition and its manifestations may in no way render one ineligible for the receipt of services normally provided. However, if there is adherence to State Regulations, one with this disease may not be admitted nor retained in a nursing home, which could violate 45 CFR Part 84.

Determination

It is our preliminary determination, based upon the preceding discussion, that Section 57.809 as written violates Section 504 of the Rehabilitation Act and its implementing Regulation 45 CFR Section 84.4 and Section 84.52 (a)(1).

Remedy

In order to voluntarily resolve this deficiency, we suggest you delete "who are, or become mentally ill and" from the paragraph at 57.809A. Please disseminate the revisions to the public, referral sources and the State's skilled care facilities.

For your reference, we have enclosed a copy of each of the pertinent Regulations.

Please advise us of your plans to correct these deficiencies. We would appreciate a response by November 12, 1985.

If you need technical assistance or if you should have any comments or questions, please contact Ms. Barbara Banks, Director, Investigations Division, at (215) 596-6173.

We appreciate your continuous cooperation.

Sincerely yours,

Paul F. Cushing

Paul F. Cushing, Regional Manager
Office for Civil Rights
Region III

Enclosures

STATE OF DELAWARE
DEPARTMENT OF JUSTICE
STATE OFFICE BUILDING
820 N. FRENCH STREET, 8TH FLOOR
WILMINGTON, DELAWARE 19801

CHARLES M. OBERLY III
ATTORNEY GENERAL

DIRECT DIAL: 571-25

July 8, 1986

Mr. Paul F. Cushing
Regional Manager
Office for Civil Rights
Region III
P.O. Box 13716
Philadelphia, PA 19101

Re: Delaware's Nursing Home Regulations for Skilled Care

Dear Mr. Cushing:

Please be advised that effective June 1, 1986, Sections 57.809 and 57.3 of Delaware's Nursing Home Regulations for Skilled Care have been deleted. Notice of this deletion is being sent to all licensed providers. I have enclosed a copy of the May 2, 1986 minutes for your information.

As I have previously advised your office, it remains the position of the Delaware State Board of Health that there has been no discrimination based on age or mental illness and that these sections were promulgated to assist in the appropriate care and placement of clients. The Board has determined that these needs can be met through inspections by Health Facilities Licensing and Certification.

If you have any further questions, please contact me.

Very truly yours,

Patricia M. Furlong
Deputy Attorney General

PMF/rd
Encl.
Xc: Hon. Thomas P. Eichler, Secretary
Lyman J. Olsen, M.D.
James E. Harvey

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF SERVICES FOR AGING AND ADULTS WITH PHYSICAL DISABILITIES

MEMORANDUM

DATE: January 8, 2014

TO: Ms. Elizabeth Timm
Division of Family Services

FROM: William Love, Director Wlove

RE: 17 DE:Reg. 608 (DFS Proposed Child Placing Agency Regulation)

The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) reviewed the proposed regulations regarding the *Delacare Requirements for Child Placing Agencies* as published as 17 DE Reg. 608 in the December 1, 2013, issue of the Register of Regulations. DSAAPD is concerned regarding:

- §95.1: *a licensee shall require that a foster parent applicant or approved foster parent is between twenty-one (21) years and sixty-five(65) years of age*, and

- §95.1.1: *a licensee may, at his or her own discretion, make exceptions to the above Regulation when the licensee documents that the health, safety and well-being of a child would not be endangered.*

I question the need and applicability of categorically barring anyone over 65 from becoming a foster parent simply due to his or her age. I also believe the age limit may be inconsistent with the Federal Age Discrimination Act. I recommend the regulations remove the age limit. Barring an applicant from becoming an approved foster parent should be based on an assessment which includes criteria specific to placement needs of the child and not based on an arbitrary age limit of 65.

Thank you for the opportunity to comment.

cc: Ms. Vicky Kelly, DSCYF
Mr. Brian Posey, AARP
Mr. Brian Hartman, Esq., CLASI
Ms. Daniese McMullin-Powell, DMMA
Ms. Pat Maichle, DDC
Ms. Jeanne Nutter, AARP

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18 N. WALNUT ST. • MILFORD • DELAWARE • 19963 • TELEPHONE: (302) 424-7310 • TDD: (302) 422-1415
INTERNET: WWW.DHSS.DELAWARE.GOV/DSAAPD E-MAIL: DSAAPDINFO@STATE.DE.US

KNOW ABOUT THE FEDERAL LAW THAT PROTECTS AGAINST AGE DISCRIMINATION

OFFICE FOR CIVIL RIGHTS

What is the Age Discrimination Act?

The Age Discrimination Act of 1975 is a national law that prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance. The Age Discrimination Act applies to persons of all ages. Under the Age Act, recipients of federal financial assistance may not exclude, deny or limit services to, or otherwise discriminate against, persons on the basis of age.

The Age Act does not cover employment discrimination, which is enforced by the Equal Employment Opportunity Commission (EEOC).

The Office for Civil Rights (OCR), at the U.S. Department of Health and Human Services (HHS), ensures that entities that receive federal financial assistance comply with this law.

The Age Discrimination Act contains certain exceptions that allow, under limited circumstances, the use of age distinctions or factors other than age. For example, the Age Discrimination Act does not apply to an age distinction contained in a Federal, State or Local statute or ordinance adopted by an elected, general purpose legislative body that: provides any benefits or assistance to persons based on age; establishes criteria for participation in age-related terms; or describes intended beneficiaries or target groups in age-related terms.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
H.H.H. Building, Room 509-F
Washington, D.C. 20201

TELEPHONE
1-800-368-1019

E-MAIL
ocrmail@hhs.gov

TDD
1-800-537-7697

www.hhs.gov/ocr

How to file a complaint of discrimination with the Office for Civil Rights (OCR)

If you believe that you or someone else has been discriminated against because of age by an entity receiving financial assistance from HHS, you or your legal representative may file a complaint with OCR. Complaints must be filed within 180 days from the date of the alleged discrimination.

You may send a written complaint or you may complete and send OCR the Complaint Form available on our webpage at www.hhs.gov/ocr. The complaint form is also available on our webpage in a number of other languages under the Civil Rights Information in Other Languages section.

The following information must be included:

- Your name, address and telephone number.
- You must sign your name on everything you write. If you file a complaint on someone's behalf — e.g. spouse, friend, client, etc. — include your name, address, telephone number, and statement of your relationship to that person.
- Name and address of the institution or agency you believe discriminated.
- When, how and why you believe discrimination occurred.
- Any other relevant information.

If you mail the complaint, be sure to send it to the attention of the regional manager at the appropriate OCR regional office. OCR has ten regional offices and each regional office covers specific states. Complaints may also be mailed to OCR Headquarters at the following address:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW.
H.H.H. Building, Room 509-F
Washington, D.C. 20201

To learn more:
Visit us online at www.hhs.gov/ocr
Call us toll-free at 1-800-368-1019
Email us: ocrmail@hhs.gov
TDD: 1-800-537-7697

Language assistance services for OCR matters are available and provided free of charge. OCR services are accessible to persons with disabilities.

www.hhs.gov/ocr

AROUND DELAWARE

Harbor Healthcare settles U.S., Del. lawsuit

The United States and Delaware reached a $150,000 settlement with Harbor Healthcare and Rehabilitation Center in Lewes related to allegations that care provided to children from 1998 through 1999 was inadequate. U.S. Attorney for Delaware Colm F. Connolly and Delaware Attorney General M. Jane Brady alleged Harbor submitted false claims to the government for payment since much of the care of a number of severely disabled children was inadequate. The government also alleged the center was understaffed and not properly trained. A lump sum of $120,000 in the settlement will be paid to the government and a $30,000 fund will be used to help Harbor's current patients. Harbor also is required to agree to have a neutral consultant monitor inspect the facility and report on its compliance. The monitor will cost Harbor as much as $125,000.

11-11-05 NJ

Long-term care gets overhaul

Guidelines geared to kids

By KIM DOUGLASS
Staff reporter

Delaware's new rules governing how chronically ill children should be cared for in nursing homes could be in place this year.

But the rules prompted by the deaths of several children in a Lewes-area nursing home in the late 1990s could be moot once they are reviewed and adopted.

Long-term care facilities in the state are designed primarily for adults, and state officials said they know of only about one or two children being cared for in a Delaware nursing home.

Most chronically ill Delaware children are being treated at home or out of state, and virtually all of them are covered under Medicaid, said Phil Soule, the state's Medicaid director.

Private insurance often will not cover such long-term care, and few families could afford the expenses, he said.

Yrene Waldron of the Delaware Health Care Facilities Association said that's unlikely to change, in part because caring for chronically ill children is very expensive.

"I know of no facility that's going to accept pediatric patients," she said. "The reimbursement for these types of clients is not commensurate with the cost of providing care."

Waldron said the new regulations make sense, but could make it even less likely that a nursing home would get into the business of long-term care for children.

In part, that's because the rules call for staff with specialties that are hard to find in Delaware, Waldron said.

But Sen. Robert Marshall, D-Wilmington West, an advocate for nursing-home reform, said the rules are important because some Delaware facilities could decide to go into the business of caring for children.

> The rules call for such things as appropriately sized medical equipment and adequate, clean clothing for the children, who might suffer from severe injuries, birth defects or diseases.

The rules call for such things as appropriately sized medical equipment and adequate, clean clothing for the children, who might suffer from severe injuries, birth defects or diseases.

The rules were drafted by the Division of Long-Term Care Residents Protection, and will be presented to the public for review during a hearing early this year.

Carey Slagle's son is among those being cared for in a home setting.

He was severely injured in a traffic accident about 10 years ago when he was 23 months old, and has been a resident of a Delaware nursing home for most of his life.

But that facility is trying to get out of the business of caring for children and urged Slagle to find a new setting for her son, she said.

The 30-year-old Middletown woman lives in a trailer and has two other

See RULES — B2

Rules: Long-term care for kids adjusted

FROM PAGE B1

children and could not care for her son at home, she said.

A Bear nurse agreed to take him into her home, and he has been in good hands there, Slagle said.

Slagle is glad for the new rules governing how children such as her son are cared for.

The nursing home took care of her son medically, she said. But "the kids would be in their rooms for hours at a time by themselves."

Her son sometimes was not bathed for days at a time, she said.

Eight Delawareans younger than 21 are being cared for in the Voorhees Pediatric Facility in New Jersey, which is designed for children. It costs on average $500,000 a year per child in Medicaid money, Soule said.

That facility has a waiting list, he said.

Soule's office also pays for 190 sick Delaware children being cared for at home. Their expenses vary, but it generally costs less than it would if they were being treated at Voorhees, Soule said.

It would be hard for a Delaware facility comparable to the one at Voorhees to thrive because of the limited number of local children who need to be institutionalized, Soule said.

"You can't run a facility efficiently with 15 kids," he said.

Delaware's new rules stem from investigations in the late 1990s after the deaths of six young patients at the Harbor Healthcare & Rehabilitation Center in Lewes between April 1998 and January 1999.

That facility was primarily in the business of caring for senior citizens, but operated a pediatric wing throughout the 1990s.

It was cited by the state in recent years for the care it provided children, and started to get out of that business earlier this year.

▶Reach Kim Douglass at 324-2895 or kdouglass@delawareonline.com.

Division of Developmental Disabilities Services

Source: DDDS Client Registry Syste

MONTHLY CENSUS REPORT

December 2013

		Number as of the last day of the month
A. STOCKLEY CENTER		
MARY ANN COVERDALE CENTER		48
102 WAPLES WAY (ICF/MR)		12
	A.	**60**

B. COMMUNITY SERVICES/ RESIDENTIAL PLACEMENTS	NEW CASTLE	KENT	SUSSEX		
NEIGHBORHOOD (GROUP) HOMES including CLA2 & CLA3	560	98	152		810
SUPPORTED LIVING	10	4	14		28
SHARED LIVING	22	54	48		124
OUT OF STATE	20	1	1		22
ETLA (Emergency Temporary Living Arrangement)	4	2	4		10
				B.	**994**
C. DPC (DELAWARE PSYCHIATRIC CENTER)	2	0	0	**C.**	**2**
D. FAMILY SUPPORT	1480	594	616	**D.**	**2,690**

E. NURSING HOMES	NEW CASTLE	KENT	SUSSEX	OUT OF STATE		
NURSING HOMES	24	7	5	1	**E**	**37**

Total Census: (A to E)	**3783**

Attachment "D"

Completed 1/16/14 lo

Census Comparison First Quarter FY 13 to First Quarter FY 14		Change During FY13	July, 2013	August, 2013	September, 2013	Difference Since Start of FY14	October, 2013	November, 2013	December, 2013	Difference Since Start of FY14
A. STOCKLEY CENTER CENSUS	A.	-3	61	61	61	0	60	59	60	-1
B. COMMUNITY SERVICES/ RESIDENTIAL PLACEMENTS										
NEIGHBORHOOD (GROUP) HOMES			768	792	792	24	785	814	810	42
SUPPORTED LIVING			18	22	23	5	23	28	28	10
SHARED LIVING			121	125	129	8	128	125	124	3
OUT OF STATE			22	22	22	0	31	22	22	0
ETLA			21	9	12	-9	13	7	10	-11
Total Placements	B.	107	950	970	978	28	980	906	994	44
C. PSYCHIATRIC PLACEMENTS	C.	-1	2	2	2	0	2	2	2	0
D. FAMILY SUPPORT	D.	142	2,625	2,629	2,664	39	2,658	2,662	2,690	65
E. NURSING HOME CENSUS										
NURSING HOME CENSUS	E	-2	27	37	38	11	35	38	37	10
Total Census: (A to E)		243	3665	3699	3743	78	3735	3757	3783	118

The Delaware Code (31 Del. C. 520) provides for judicial review of hearing decisions. In order to have a review of the decision expressed below in Court, a notice of appeal must be filed with the clerk (Prothonotary) of the Superior Court within 30 days of the date of the decision. An appeal may result in a reversal of the decision. Readers are directed to notify the DSS Hearing Office, P.O. Box 906, New Castle, DE 19720 of any formal errors in the text so that corrections may be made.

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

In re:
A G, a minor

DCIS No.:
5000703852

Appearances: Marybeth Putnick, Disabilities Law Program, Community Legal Aid Society, Inc., Counsel for the Claimant
, Claimant's Parent, Witness
Donna Carroll, Clinical Social Worker, Brandywine School District, Witness

Jennifer Gimler Brady, Counsel for the First State Health Plan
Tricia Strusowski, R.N., First State Health Plan, Witness
Libby Walker, R.N., Supervisor, Pre-Certification Department, First State Health Plan, Witness[1]

I

A G (sometimes hereinafter the "claimant"), through counsel and her parent A opposes a March 16, 2000 decision of the First State Health Plan (sometimes "First State") to deny a request for in-home speech therapy.

First State contends that it is a responsibility of the claimant's school district to provide speech therapy services and not a responsibility of the First State Health Plan.

The claimant contends that speech therapy is medically necessary for her, that First State is obligated to arrange for medically necessary covered services under the Medicaid Program, that her doctors have expressly prescribed speech therapy at home, and that First State may not lawfully deny her claim for speech therapy services on grounds that the services are part of the individualized education plan developed by her school.

[1] Thomas Mannis, M.D., the Medical Director for the First State Health Plan also attended this hearing.

II

In November and December 1999 First State denied requests for speech therapy for the claimant on grounds that "speech therapy for the condition of developmental delays is not a covered benefit" and because the therapy "is already being provided through [the claimant's] school." [Exhibit # 2]

On December 9, 1999, following an appeal to Christiana Care Health Plans, First State affirmed the denial on grounds that "the therapy is not medically necessary in addition to the school based therapy." By notice dated March 16, 2000, Christiana Care reaffirmed the decision. [Exhibit # 2]

On March 29, 2000 A _____ filed a request for a Fair Hearing with the Division of Social Services. [Exhibit # 1]

The hearing was conducted on June 12, 2000 at the Lewis Building of the Department of Health and Social Services in New Castle.

This is the decision resulting from that hearing.

III

The Division of Social Services of the Department of Health and Social Services operates several medical assistance programs including the State funded Chronic Renal Diseases Program[2], the Medicaid Program under Title XIX of the Social Security Act, the "QMB" Program[3] which is a Medicare Program that is partly funded with Medicaid Program money, and the "Delaware Healthy Children Program"[4] funded by Title XXI of the Act. The Division derives authority for the operation of the Medicaid Program from 31 Del. C. §502(5), §503 (b), and §505 (3).

The Medicaid Program provides support for medical services received by defined groups of low-income families and individuals. Persons who meet income and status eligibility tests, such as age, citizenship, and residency, may participate in the program. Participants qualify for payment for a wide range of medical services.

The First State Health Plan is a capitated[5] managed care program offered by Christiana Care Health Services to direct, on behalf of the Division of Social Services, benefits covered under Title XIX of the Social Security Act.

A _____ is a third party beneficiary of a contract between First State and the Division of Social Services. She is a four-year-old

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[2] 29 Del. C. §§ 7932-7935.

[3] Section 17300 DSSM.

Section 18000 DSSM.

[5] See 42 CFR 434.2. A capitation fee is paid by DSS to managed care contractors "for each recipient enrolled under a contract for the provision of medical services under the State plan, whether or not the recipient receives the services during the period covered by the fee."

youngster who receives medical assistance under the DSS Disabled

Children's medical assistance program.[6] She is diagnosed with buccolingual dyspraxia, expressive and receptive language delays and significant articulation problems.

First State contracts with DSS to provide comprehensive prepaid managed care health services to persons who receive Medicaid. A purpose of managed care is to "stabilize the rate of growth in health care costs."[7]

Jurisdiction for this hearing is under §5304.3 of the Division of Social Services Manual (DSSM). Section 5304.3 provides jurisdiction for a hearing over an adverse decision of a Managed Care Organization.

IV

The essential facts in this case are not in dispute. The claimant resides with her parents in and receives educational services from the Bush Early Education Center of the Brandywine School District. She is enrolled in a specialized education program where she receives speech therapy services twice a week. She is eligible to receive services for an "extended school year." Her school speech therapy is an educational service covered under the Individuals with Disabilities Education Act[8]. She meets the definition of a child with a disability at 20 U.S.C. §1401 (3)(A)(i). She has a specific learning disability.

First State has denied a request for authorization of an additional weekly in-home speech therapy session and speech therapy services during the months of August and September when her school is out of session.

The claimant's pediatric neurologist S. Charles Bean, M.D. has prescribed in-home speech therapy for her. [Exhibits # 2 and # 8] It is thought that in-home speech therapy will improve her functional communication skills, that it serves a different purpose from speech therapy in school, and that therapy in the home environment is less stressful than therapy given in the claimant's school and, therefore, is more beneficial to her. School-based speech therapy is not available to her during the months of August and part of September. It is believed that speech therapy is needed during these months to prevent regression of her language skills.

According to First State, the claim was denied because the speech therapy services are an educational obligation of the claimant's school district. It is undisputed that speech therapy is an educational obligation of the school.

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[6] See §17200 DSSM. The Delaware Disabled Children's program is analogous to the program described in the federal rule at 45 CFR 435.225. The State program requires a level of care determination rather than the determination, found in the federal rule, that the child qualify as a disabled individual under section 1614(a) of the Social Security Act.

[7] Diamond State Health Plan, July 27, 1994, Chapter 1-1.

[8] 20 U.S.C. §1400 et seq.

However, the First State position that it, consequently, has no obligation to arrange for speech therapy services that the school does not provide is not supported by the law at 42 U.S.C.A. §1396b, which provides:

> (c) *Treatment of educationally-related services*
>
> Nothing in this subchapter shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) of this section for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to Part B of the Individuals with Disabilities Education Act [20 U.S.C.A. §1411 et seq.] or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act [20 U.S.C.A. §1471 et seq.]
>
> **United States Code Annotated,** *Title 42 §§ 1395ee to 1399,* 2000 Supplementary Pamphlet, West Group.

Since the Secretary of the United States Department of Health and Human Services is prohibited by law from denying claims for speech therapy services under the Medicaid Program because an individual is able to receive those services from a school district when the services are educationally indicated, it follows that the Delaware Department of Health and Social Services, the Division of Social Services, and the Division's agent, the First State Health Plan, are likewise prohibited from denying [illegible]' claim for medically necessary supplemental speech therapy services.

For this reason, the March 16, 2000 decision of First State, affirming an earlier denial because speech therapy was received at the claimant's school and denying a request for additional speech therapy services on grounds that the services are an obligation of the claimant's school district, is reversed.

HEARING OFFICER

June 22 2000
DATE

THE FOREGOING IS THE FINAL DECISION OF THE DIVISION OF SOCIAL SERVICES

JUN 2 2 2000
POSTED

c: Marybeth Putkin for the Claimant
Jennifer Gimler Brady for the First State Health Plan

DOCUMENTS FILED IN OR FOR THE PROCEEDING

Exhibit # 1 is a request for a fair hearing dated March 29, 2000.

Exhibit # 2 (six pages) is a two page hearing summary of the First State Health Plan together with four pages of speech therapy denial notices dated November 30, 1999, December 7, 1999, December 9, 1999, and March 16, 2000.

Exhibit # 3 (four pages) is a photocopy of a November 30, 1999 speech therapy evaluation of the claimant. This is offered by First State to show the overlay between the speech therapy and educational goals for the claimant.

Exhibit # 4 (approximately twelve pages) is an individualized education program for the claimant. This is offered by First State to show the overlay between the speech therapy and educational goals for the claimant.

Exhibit # 5 (approximately 22 pages) consists of photocopies of Nurses 'N Kids at Home, Inc. speech therapy weekly progress notes from 11/30/99 to 5/25/00. These are offered by the claimant to show progress made as a result of her in-home speech therapy and to show the difference between at-school and in-home therapies. The latter claim is rejected because there are no comparable school district reports. They are admitted pursuant to §5404 (5).

Exhibit # 6 (three pages) is a photocopy of a Nurses 'n Kids at Home speech therapy progress update dated May 15, 2000. This is offered by the claimant to show progress made as a result of her in-home speech therapy and is admitted pursuant to §5404 (5).

Exhibit # 7 is a statement made outside the hearing by S. Charles Bean, M.D. dated June 9, 2000 about the claimant's need for speech therapy services. It is offered by the claimant and is included over objection for relevance pursuant to §5404 (5).

Exhibit # 8 (four pages) consists of photocopies of a letter from S. Charles Bean, M.D. dated October 28, 1999, a letter from Charles I. Scott, Jr., M.D. dated December 2, 1999, a letter from Joseph DiSanto, M.D. dated January 17, 2000 and a letter from Denise Yeatman dated January 21, 2000. These are offered by the claimant in support of the position that in-home speech therapy one day per week is medically necessary. They are included pursuant to §5404 (5) DSSM.

Exhibit # 9 is a photocopy of a letter dated November 29, 1999 from Donna Carroll to the First State Health Plan. This is included pursuant to §5404 (5).

National Association of Protection and Advocacy Systems Q & A: Using Medicaid to Cover Services Provided in School

National Health Law Program
Sarah Somers
May 2006

Question: Some of my clients are children with disabilities who are eligible both for Medicaid services and for special education services in school. Some of the services that they receive in school, like speech therapy, are also covered by Medicaid. Can Medicaid pay for these special education services if they are provided in schools?

Answer: Many medically necessary services that children with disabilities receive in schools can be paid for by Medicaid.

The Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1401 *et. seq.,* requires that children with disabilities receive a free, appropriate public education which consists of special education and "related services." Related services are transportation and developmental, corrective, and other supportive services that may be required to assist a child with a disability to benefit from special education. 20 U.S.C. §

1402(22). The law specifies that these services include speech pathology, physical and occupational therapy, psychological services and diagnostic medical services. *Id.* Special education and related services are provided pursuant to an Individual Education Program Plan (IEP) which contains educational goals and objectives for a child, and is drafted by a team consisting of teachers, parents and other professional who work with the child. 20 U.S.C. §§ 1401(11), 1414(d).

Some of the related IDEA services are identical to those provided under Medicaid. Medicaid services also include diagnostic services, physical and occupational therapy services and psychological services. 42 U.S.C. § 1396d. Under Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), children and youth under 21 are entitled to any necessary health care, diagnostic services, treatment and other measures described in the Medicaid Act which the child needs to correct or ameliorate physical and mental illnesses and conditions. 42 U.S.C. § 1396d(r).

Some related services can be paid for by Medicaid. In fact, the Medicaid statute specifically forbids the federal government from refusing to pay for Medicaid services that are provided to a child with a disability as part of the child's IEP. 42 U.S.C. § 1396b(c). In addition, 34 C.F.R. § 300.601 provides that "Part B of [IDEA] may not be construed to permit a State to reduce medical and other assistance available to children with disabilities, or to alter the eligibility of a child with a disability, under title V (Maternal and Child Health) or title XIX

(Medicaid) of the Social Security Act, to receive services that are also part of FAPE." In order to be covered:: (1) services must be medically necessary and coverable under a Medicaid coverage category; (2) all relevant federal and state regulations must be followed; and (3) the services must be included in the state's plan or be available under EPSDT. In order to bill for services, however, the school must be a participating Medicaid provider. *See e.g.* Letter from Christine Nye to Director, Medicaid Bureau (May 17, 1991); Chicago Regional State Letter No. 34-91 (June 1991); Title XIX State Agency Letter No. 91-52, Region X (July 3, 1991) (available from NHELP). Moreover, Medicaid agencies cannot restrict providers of services to schools. *See e.g.* Chicago Regional State Letter No. 34-91 (June 1991); *see also Chisholm v. Hood,* 110 F. Supp. 2d 499 (E.D. La. 2000) (holding that restricting Medicaid providers of speech, occupational and physical therapy services to school boards violated Medicaid Act).

A specific exception is applicable to some home and community-based waiver services. The Medicaid Act allows states to adopt special home and community-based (HCB) waiver programs. These programs allow states to waive some Medicaid requirements, such as financial eligibility rules, to offer services to targeted populations or areas. Under these programs, states can offer additional services that otherwise could not be covered by Medicaid. 42 U.S.C. § 1396n(c). One such service is habilitation, defined by the Act as "services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills

necessary to reside successfully in home and community based settings. . ." 42 U.S.C. § 1396n(c)(5)(A). However, habilitation services cannot be covered if they are also special education or related services. 42 U.S.C. § 1396n(c)(5)(C)(i). So, if habilitation services are provided pursuant as part of a child's special education program, the school will probably not be able to get Medicaid reimbursement for them.

EXCERPT

HHS Policy Clarification

Prepared for: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services
In cooperation with: Health Care Financing Administration, U.S. Department of Health and Human Services, and the Office of Special Education and Rehabilitative Services, U.S. Department of Education
Prepared by: Lewin/ICF, a division of Health & Sciences International, and Fox Health Policy Consultants
November 1991

The U.S. Department of Health and Human Services (HHS), in cooperation with HCFA and OSERS, issued a policy clarification on the use of Medicaid funds in the provision of health-related services under the IDEA. The purpose of the joint policy statement was to explain, in plain language, the extent to which services contained in an IEP under Part B can be reimbursed by Medicaid. The HHS guidance was intended to encourage state and local educational agencies to cooperate more closely with state Medicaid agencies in the provision and funding of special education and related services.

Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An Examination of Federal Policies

Overview

Part B of the Individuals with Disabilities Education Act (IDEA) authorizes Federal funding to states in order to ensure that children with one or more of thirteen specified disabilities receive a free appropriate public education. The law was established by Public Law 94-142 and was formerly called the Education of the Handicapped Act. Under the law, school districts must prepare an Individualized Education Program (IEP) for each child eligible for services under Part B, specifying all special education and "related services" needed by the child. A state Medicaid program can pay for those "related services" that are specified in the Federal Medicaid statute and determined to be medically necessary by the state Medicaid agency.

Within Federal and state Medicaid program requirements regarding allowable services and providers, school districts can bill the Medicaid program for these health-related services when provided to children enrolled in Medicaid. This is important because of the additional financing it offers to educational agencies. The Part B program requires states to provide all special education and related services to eligible students at no cost to parents, but many states find this difficult because they are constrained by limited education budgets.

This booklet is designed to help state and local education officials, Medicaid officials, and other interested parties understand the conditions under which the Medicaid program can pay for the related services required by an IEP. It also describes the extent to which state Medicaid eligibility, coverage, and reimbursement policies are governed by Federal law.[1]

The booklet is organized in a "Question and Answer" format. We strongly recommend that the reader review the complete range of questions and answers given the complexity of the issues presented. The remainder of this overview provides background information on the two relevant programs: the Assistance to States Program established under Part B of IDEA, and the Federal/state Medicaid program established under Title XIX of the Social Security Act. A list of the questions addressed by the booklet is provided in Exhibit 1.

A. The Part B Program

The Federal entitlement program that governs services to children with one or more of thirteen specified physical or mental disabilities who by reason thereof require special education and related services is authorized under Part B of the Individuals with Disabilities Education Act.[2] The Part B program is administered by the Office of Special Education and Rehabilitative Services within the U.S. Department of Education. Grants are distributed to states, which then disburse most of the funds to local education agencies (e.g., school districts) to support their special education activities.

The grants under Part B are intended to assist states in assuring that children with specified disabilities receive a free appropriate public education as specified in the Act. A "free appropriate public education" is defined to include special education and related services at no cost to the parents.

- "Special education" is defined as "specially designed instruction, at no cost to the parent, to meet the unique needs of a child with a disability." It can include classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions to ensure that children with disabilities receive a free appropriate public education.

- "Related services" are defined as "transportation, and such developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education." These include several health-related services that must be available, including speech pathology, audiology, psychological services, physical and occupational therapy, early identification and assessment of disabilities, counseling services, school health services, social work services in schools, and medical services for evaluation and diagnostic purposes only.[3]

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Although states and localities fund the bulk of special education services, Federal Part B funds are an important supplement. To receive Part B funds, a state must submit a plan through its state education agency (SEA) detailing state policy for ensuring that children with specified disabilities have access to a free appropriate public education. The state application also must include an estimate of the total number of children with disabilities currently receiving and/or in need of special education and related services. The state must also provide estimates of the personnel and other resources necessary to meet the special education needs of children as specified by the Act. The distribution of funds among states is determined by a formula based on the number of children with disabilities age 3 through 21 receiving special education and related services within each state.

Once Part B monies have been approved, they are forwarded to the SEA for distribution to local education agencies (LEAs). LEAs generally are comprised of one or more local school districts. The LEAs receive funds only after they have submitted a program plan and been granted approval by the SEA. The LEAs are then expected to provide services to students with specified disabilities. State and local education agencies are prohibited from reducing their existing financial commitments to special education in response to the receipt of Part B funds.

For students with specified disabilities eligible for special education services under Part B, an Individualized Education Program (EIP) must be developed cooperatively by the school, the child's teacher, the child's parent or guardian, and others if deemed appropriate. Developed by the beginning of the school year, and reviewed (and if appropriate revised) at least annually, the IEP must detail specific special education and related services that are to be provided to the child. The LEA is responsible for assuring that all services included in the IEP are provided to the child and that education occurs in the "least restrictive environment," meaning that the child is educated with non-disabled peers to the maximum extent appropriate.

B. The Medicaid Program

Medicaid is a nationwide Federal/state medical assistance program for selected low-income populations. The Medicaid program was established in 1965 as Title XIX of the Social Security Act. It is federally administered by the Health Care Financing Administration (HCFA) within the U.S. Department of Health and Human Services (DHHS). While Congress and HCFA set broad Federal guidelines for the program, states have considerable flexibility in formulating eligibility, benefits, and reimbursement policies. Every state documents these policies in a state Medicaid plan which must be approved by HCFA.

The Medicaid program is funded by a combination of Federal and state dollars. The Federal Government "matches" state dollars as long as both the services and the eligible populations are within the parameters approved in the state plan. The level of the Federal match, known as Federal Financial Participation (FFP), is determined by a formula based on state per capita income. The minimum FFP in state expenditures for medical services is 50 percent of total program costs; the maximum FFP is 83 percent.

Medicaid is a "categorical," means-tested program. Individuals must fit into specific categories (e.g., dependent children) and must have income and resources below specified thresholds. Until recently, Medicaid eligibility was linked almost exclusively to eligibility for Federally funded cash assistance under two programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). AFDC and SSI are "categorical" programs. AFDC recipients live in families with a single or unemployed parent and SSI recipients are aged, blind, or disabled. States are also able to establish "Medically Needy" programs to cover individuals who meet the categorical eligibility criteria for cash assistance but not the income and resource eligibility criteria. Under a Medically Needy program, states may extend eligibility to individuals with family incomes up to 133 percent of the state's AFDC payment standard and also to individuals who incur health expenses which, when deducted from income, bring their net income below the medically needy level.

Recent Federal legislation has diminished the link between eligibility for cash assistance and Medicaid. Medicaid has been expanded to include many young children with family incomes and resources well above state eligibility standards for cash assistance. Moreover, many of these children qualify for Medicaid regardless of whether they have disabilities or are in single-parent families.

Medicaid covers a broad range of medical and remedial services. Federally allowable services include not only traditional medical services and remedial care, such as physicans' services and prescription drugs, but also several health and therapeutic interventions, such as occupational therapy. Some services are mandated by Federal law and must be provided by every state, while other services are provided at a state's discretion. One special program established for children is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Under the EPSDT program, children must receive not only screening and diagnostic services, but also any medically necessary treatments that may not otherwise be available under a state's Medicaid plan but are allowable under Federal Medicaid law.

Medicaid services may be provided by a range of health professionals in a variety of settings, including a child's home or school. However, in defining service benefits, states have some latitude in specifying the types of providers and settings in which services must be provided in order to be reimbursable.

In general, state Medicaid programs pay participating providers for covered services on a per unit of service basis (such as a physician office visit). Within Federal guidelines, states have flexibility in determining reimbursement rates for particular services and providers. Providers generally bill Medicaid directly for payment for covered services provided to medicaid recipients. States have the option of requiring nominal cost-sharing by Medicaid recipients for some services, meaning that the recipient pays a small "copayment" (e.g., $2.00) to the provider for a given service.

In sum, states have considerable flexibility in defining Medicaid eligibility groups, benefits, provider participation requirements, and reimbursement levels within Federal guidelines. It is because of this flexibility that states can shape their programs to include reimbursement for health-related services

required under the Part B program, a process that can be facilitated through interagency agreements between the state's Medicaid agency and education agencies.

C. Questions Addressed By The Handbook

Federal policy has established that education agencies can bill Medicaid for health-related services covered under the state's Medicaid program. However, there has been considerable confusion about Federal policy, and the various laws and regulations governing the billing and reimbursement process can be complicated and ambiguous. This booklet seeks to clarify the relevant Federal policies in response to the questions shown in Exhibit 1. (Exhibit 1 Omitted)

Questions and Answers

A. Idea Policy Regarding Medicaid Billing

1. Does Federal Part B policy allow Medicaid billing for health-related services covered under a state's Medicaid program. . . .

Yes. Although Part B does not expressly require Medicaid billing for covered health-related services, Congress anticipated the use of Medicaid and other resources to finance health-related Part B services. The Senate Report accompanying the original act, P.L. 94-142, states that "the state education agency is responsible for assuring that funds for the education of handicapped children under other Federal laws will be utilized" and that "there are local and state funds and other Federal funds available to assist in this process."

Moreover, three statutory amendments to Part B, made in 1986 by P.L. 99-457, further support the use of Medicaid and other sources to finance IEP-related services. Under these amendments:

- States are prohibited from using Part B funds to satisfy a financial commitment for services that would have been paid for by other Federal, state, and local agencies but for the enactment of Part B and the listing of the services in an IEP;
- States are required to establish interagency agreements with appropriate state agencies to define the responsibility of each for providing or paying for a free appropriate public education and resolving disputes; and
- It is clarified that P.L. 94-142 cannot be construed as permitting a state to reduce medical or other available assistance, or to alter Title V Maternal and Child Health Block Grant or Medicaid eligibility with respect to the provision of a free appropriate public education.

2. Are there any Federal special education policies that limit the circumstances under which the Medicaid program can be billed for health-related services?

The only Federal education policy that could restrict Medicaid payment for covered health services is the basic IDEA requirement that special education services be provided "at no cost to parents." The effect of this provision is that state or local education agencies must assume any costs the Medicaid agency does not pay for so that no costs are imposed on the parents. For example, if the state Medicaid agency has elected to exercise its Federal option to impose nominal cost-sharing requirements on Medicaid recipients for services that include health-related services furnished by schools, the state or local education agency would be required to meet these copayment obligations for an eligible family.[4]

B. Medicaid Policy Regarding Payment For Health-Related Services

1. What are the Federal Medicaid program requirements regarding reimbursement for health-related services?

The Federal Medicaid statute does not require that Medicaid programs reimburse schools for health-related services delivered to Medicaid-eligible children. However, the Medicare Catastrophic Coverage Act of 1988 (MCCA) amended the law to make clear that Medicaid funds are available to pay for health-related services.[5] The amendment states that nothing under the Medicaid statute is to be construed as prohibiting or restricting, or authorizing HCFA to prohibit or restrict, payment for services covered under a Medicaid state plan simply because they are furnished to a handicapped child pursuant to an individualized education program (IEP). The implication, as explained in the Conference Report, is that state education agencies are responsible for furnishing special instruction and educational services to children with disabilities, but that state Medicaid agencies are responsible for reimbursing health-related services provided to Medicaid-eligible children to the extent the state covers them under its Medicaid plan.

2. Are there any Federal Medicaid policies that limit the circumstances under which the Medicaid program can be billed for health-related services?

Under Federal law, the Medicaid program can only be billed for medically necessary services that are included in the state's Medicaid plan and provided by participating Medicaid providers. An exception to this is services provided under the EPSDT program (see Section C). In addition, except under circumstances described in Section F, Medicaid does not pay medical expenses that a third party, such as a private insurance company, is legally obligated to pay.

3. What state Medicaid policies must be in place in order for schools to bill Medicaid for medically necessary health-related services?

In order for schools to be able to bill Medicaid, the state Medicaid program must cover the various health-related services a child may need (e.g., physical therapy) under one of the service categories in its Medicaid state plan. In addition, the state Medicaid agency needs to have qualifications for providers of health-related services that schools or their practitioners would be able to meet (see Section E for a discussion of provider qualifications). These policies need to be reflected in the state Medicaid plan (see section G). However, while the state Medicaid agency can establish qualifications which would allow schools or their practitioners to be providers, it may not specify schools or their practitioners as the sole providers of health-related services.

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