



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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MEMORANDUM

DATE: March 12, 2014

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 17 DE Reg. 930 [DMMA Prop. Pathways to Emp. Medicaid Plan Amendment Reg.]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposal to adopt a Medicaid State Plan amendment to establish a "Pathways to Employment" program. The proposed regulation was published as 17 DE Reg. 930 in the March 1, 2014 issue of the Register of Regulations.

SCPD commented on this initiative originally published in the January 2014 Register of Regulations. A copy of the January 30, 2014 SCPD memo is attached for facilitated reference. However, since a concept paper and draft Plan amendment were not included in a DMMA link until January 17th, DMMA is extending the opportunity to comment until March 31, 2014. Since the only document which SCPD lacked when compiling the previous analysis of the regulation in January was the 55-page Plan amendment, Council is providing a supplemental analysis focusing on that document.

p. 1: SCPD questions why individuals with visual impairments are eligible for only 5 services while individuals with all other qualifying impairments are eligible for 9 services. Individuals with visual impairments would be categorically barred from receiving the following Pathways services available to individuals with other qualifying impairments: 1) career exploration and assessment; 2) small group supported employment; 3) individual supported employment; and 4) personal care. SCPD recommends uniformity in the services menu.

p. 4: The Division envisions the establishment of “a consumer council within the organization to monitor issues of choice”. SCPD did not identify any other references to the council. It could be useful to include the council in the quality improvement section (pp. 40 et seq) and otherwise clarify the structure and role of the council.

p. 4: In its January 30 commentary, the SCPD recommended an explicit recital that the fair hearing process applies to disputes. This is clarified at p. 4 (Par. 5) and p. 13.

p. 4: On p. 4, Par. 7, as well as on p. 8, DMMA represents that the program will not cover services otherwise available to an individual under the IDEA. There is some “tension” between such an approach and federal law which generally bars Medicaid programs from refusing to cover services available to a student under the IDEA. See attached materials. The NHLP memo (pp. 2-3) offers the following guidance:

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 the [IDEA] may not be construed to permit a State to reduce medical or 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.”

For example, if a student could receive habilitation services through the special education system, DMMA could not deny Medicaid-funded habilitation simply because it is available through the student’s special education program. Between Medicaid and the IDEA, Medicaid is generally the payer of first resort.

p. 5: DMMA identifies an income cap but does not address whether any resource cap applies. Consistent with the SCPD’s January 30 commentary, “First” paragraph, it would be preferable to clarify that there is no resource cap.

p. 7: The standard defining the credentials of persons conducting reevaluations is rather meager: For all target groups, reevaluations are conducted by individuals holding an associate’s degree or higher in a behavioral, social sciences, or a related field OR experience in health or human services support which includes interviewing individuals and assessing personal, health, employment, social or financial needs in accordance with program requirements.

This standard is reiterated at pp. 11-12 and 15. An Employment Navigator preparing a plan of care does not even need a high school diploma. A telephone receptionist for a non-profit or

public agency will generally meet the standard of “experience in health or human services support which includes interviewing individuals and assessing ...needs in accordance with program requirements.” Moreover, an individual with only geriatric experience would qualify under the above standard despite no familiarity with services for teens and young adults. This represents a major weakness in the proposal, especially for low-incidence populations (e.g. TBI) who have very specialized needs.

p. 7: There are no time lines for screening and processing of applications. Time lines would be useful.

p. 10: The table on p. 10 does not match DDDS eligibility standards. See attached 16 DE Admin Code Part 2100. Under DDDS standards, some conditions require low I.Q. scores while others (e.g. autism) do not. The table would literally permit Pathways eligibility of individuals with brain injury without low I.Q. scores. SCPD would strongly favor this approach. However, as the SCPD stressed in its January 30 memo, the absence of an explicit reference to brain injury under the “physical disabilities” heading is very troublesome. This concern could be addressed by amending the reference to Group B on p. 10 as follows: “Individuals age 14 to 25 with a physical disability (including brain injury); whose physical condition is anticipated to last 12 months or more.”

p. 14: In its January 30 commentary, Tenth Paragraph, the SCPD supported inclusion of references to “self-employment”. The Plan Amendment includes such references at pp. 14, 16, and 18.

p. 19: For individuals receiving individual supported employment services, job placement support appears to be capped at 6 months in a benefit year. The same cap is applied to persons receiving group supported employment services (p. 22). No rationale is provided. DMMA may wish to reconsider the merits of such a cap.

p. 21: Individuals receiving group supported employment are subject to a presumptive (but not absolute) cap of 12 continuous months. There is no comparable cap for individual supported employment (p. 19). This may be a deterrent to successful outcomes for persons with the most severe disabilities who may need more time to prove successful.

p. 26: The standards for financial coaches appear to be very generic, i.e., persons with some financial planning experience may serve as financial coaches despite little experience with disability-based planning. SCPD suspects that few financial planners are familiar with Miller Trusts, the Delaware CarePlan Trust, the Social Security PASS program, housing assistance programs, and the Social Security Administration’s Ticket to Work Program. Perhaps this level of sophistication with disability-related financial planning is achieved through the training

identified on p. 27. If that training does not address programs such as the Delaware CarePlan Trust, PASS program, and Ticket to Work, this section should be revised to require background at least equivalent to DVR's benefits planners.

p. 29: DMMA recites that the non-medical transportation service "does not provide for mileage reimbursement for a person to drive himself to work". This is objectionable and unrealistic. The transportation broker should be allowed to pay the participant to drive himself/herself to an employment or training site. This is the approach adopted by DVR. See Delaware DVR Casework Manual, §9.3. As a practical matter, if someone lives in Sussex County, use of a personal vehicle may be the only realistic and affordable option. There is negligible taxi service and no accessible taxi service. Paratransit is limited and often results in lengthy delays in reaching destinations. Finally, it is possible that the assistive technology benefit could be used to retrofit a vehicle (e.g. with hand controls). It makes no sense to facilitate a participant's driving capacity and then categorically exclude mileage reimbursement as an option.

p. 34: There are several references to the "Department of Vocational Rehabilitation" rather than "Division of Vocational Rehabilitation".

p. 35: It's somewhat "odd" to solely authorize spouses (among all relatives) to provide personal care services. Many individuals between 14-25 will not be married. It would be preferable to authorize siblings and other relatives to provide personal care services. See attached September 29, 2008 CMS Press Release and DSAAPD PAS Services Specifications, §6.2.2.2.

p. 40 et seq: The number and disposition of fair hearing requests could be incorporated into the quality improvement standards. The emphasis on "safety", "abuse/neglect", and "incidents of emergency restrictive behavior intervention strategies" (pp. 46-48) are not intuitively core benchmarks of successful employment outcomes and should be reconsidered.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our position on the proposed regulation.

cc: Mr. Stephen Groff
Ms. Lisa Zimmerman
Ms. Staci Marvel
Ms. Lisa Bond
Ms. Jane Gallivan
Ms. Marie Nonnenmacher
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

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MEMORANDUM

DATE: January 30, 2014

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

FROM: Kyle Hodges, Director
State Council for Persons with Disabilities

RE: 17 DE Reg. 688 [DMMA Proposed Pathways to Employment Medicaid Plan Amendment]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance (DMMA) proposal to adopt a Medicaid State Plan amendment to establish a "Pathways to Employment" program. The proposed regulation was published as 17 DE Reg. 688 in the January 1, 2014 issue of the Register of Regulations. The framework of the initiative is explained in the attached October 2013 concept paper entitled "Pathways to Employment: The Employment First Act- Putting Policy Into Practice" [hereinafter "Concept Paper"]. Unfortunately, although the Register recites that the actual amendment is available by following a link to the DMMA website, this is not accurate. DHSS was notified of the problem on January 2 and was advised by DMMA that it would follow up. As of January 9, the amendment was still not available on the website and still not finalized so our comments do not address the actual proposed amendment.

As background, DMMA notes that federal law authorizes states to adopt a §1915(I) State Plan amendment with two (2) advantages compared to traditional HCBS waivers. First, the amendment does not require participants to meet an institutional standard of care. Second, states cannot impose numerical limits on participation, i.e., individuals who qualify and apply must be served. DMMA proposes to seek CMS approval of the program effective July 1, 2014. The expected State cost in FY15 is \$380,000. Participants would have to be Medicaid eligible. Participants would be initially limited to individuals between the ages of 14 and 25 subject to expansion at a later date. Only individuals with certain disability profiles would be eligible: 1) individuals with visual impairments; 2) individuals with physical disabilities, including brain injury; 3) individuals with intellectual disabilities, autism spectrum disorders, and Aspergers.

The following menu of services would be included in the program:

- 1) career exploration and assessment;
- 2) supported employment (small group);
- 3) supported employment (individual);
- 4) employment navigators;
- 5) benefits counseling;
- 6) financial coaching;
- 7) non-Medical Transportation;
- 8) personal care (including a self-directed care option); and
- 9) orientation and mobility training and assistive technology.

DMMA would oversee the program which would be jointly administered by DDDS, DSAAPD, and DVI. A similar initiative is planned for individuals with mental illness through a §1115 waiver amendment.

SCPD has the following observations.

First, although DMMA identifies a financial income cap [150% of the Federal Poverty Level (FPL)], there is no mention of a resource limit. At 690. DMMA notes with approval the operation of the Medicaid Buy-in program (Medicaid Workers with Disabilities). Concept Paper at 3. That program has no resource cap. See 16 DE Admin Code 17000, §17906. It would be preferable to explicitly adopt a no-resource cap standard for the “Pathways” program.

Second, the “Pathways” program overlaps with the federal Ticket to Work program. Cf. 16 DE Admin Code 17000, §17900. Under the “Ticket” program, current SSI and SSDI beneficiaries assign their “ticket” to an employment network (EN) which is paid to facilitate the employment of the beneficiaries. See attached Social Security Administration descriptions. DMMA should address the interplay between Medicaid beneficiaries who enroll in both the Ticket program and the Pathways program. For example, could a participant in both programs receive benefits counseling, financial coaching, supported employment, etc. through both an EN and a Pathways provider?

Third, in enacting the Ticket program, Congress recognized that many SSI/SSDI beneficiaries seeking employment face legal barriers, including employment discrimination in hiring, need for employer-provided reasonable accommodations, and denials of support services. In response, Congress included a legal advocacy program as part of the Ticket legislation, the Protection and Advocacy for Beneficiaries of Social Security (PABSS) program. See attachment. DMMA could consider adding legal advocacy to the menu of services in the Pathways program. In Delaware, the Community Legal Aid Society, Inc. implements the PABSS program. DMMA could consider a contract with CLASI similar to the DSAAPD-CLASI contract using Older Americans funds for legal advocacy on behalf of seniors. This could be critical importance for the Pathways participants ages 14-21 who are enrolled in the special education system. The Concept Paper (at 4) indicates

that the Pathways program will not provide services available under the IDEA. Query how this will be enforced in practice since the entire Pathways menu of services would qualify as IDEA services for students in transition. CLASI enjoys unique special education expertise and could represent Pathways participants in securing robust IEPs with employment-related components. For older Pathways participants, CLASI could address other barriers to employment, including employment discrimination.

Fourth, there will obviously be overlap between participants in the Pathways program and the DSHP+ program. There are also overlapping services, including assistive technology and personal/attendant services. DSHP+ MCOs, which are paid per person, have a financial incentive to deflect assistive technology and personal/attendant services costs to the Pathways program. DMMA should adopt disincentives and deterrents to such practices which could result in unnecessary cost to the Pathways program. For example, DMMA could require MCOs by contract to defer and cooperate with implementation of a Pathways services plan. Compare Title 16 Del.C. §214 (MCOs required to defer to IFSPs).

Fifth, as proposed, the Pathways program may present a “Catch-22” to participants. The income cap (150% of FPL) is relatively low. In contrast, the Medicaid for Workers with Disabilities income cap is 275% of FPL. See 16 DE Admin Code 17000, §17911. There are two “downsides” to a low income cap. First, an individual who is successful in employment with Pathway supports may precipitously lose financial eligibility as earnings reach the cap. Second, participants and providers will be unduly restrained in promoting employment since reaching the income cap results in termination of Pathways eligibility. DMMA should incorporate features in the Pathways program to address disincentives to full employment. For example, DMMA could allow participants to exceed the general earned income cap for a period of 3-4 months while engaging in Pathways-sponsored supported or competitive employment.

Sixth, for 14-17 year olds with covered disabilities, many will be financially ineligible based on deeming of parental income. Cf. 16 DE Admin Code 17000, §17910. DMMA may wish to consider an exception to parental deeming for the Pathways program. Alternatively, DMMA could adopt a partial “disregard” of some parental income for the Pathways program.

Seventh, the Council shared the attached draft legislation with policymakers in 2013 which would authorize a tax credit for hiring DDDS clients. A similar bill could be developed to authorize a tax credit for hiring Pathways participants. This would enhance prospects for the success of the program since employers would have a significant incentive to hire Pathways participants. As a practical matter, DMMA could spend \$380,000 to ensure that individuals are ready for employment but be unsuccessful if employers are disinclined to hire participants. Another advantage to the legislation is that it promotes retention of the individual for a specified time period in order to qualify for the credit.

Eighth, the regulation includes the following reference to the target population: “(i)ndividuals with physical disabilities, which may include individuals with brain injury”. The use of “may” is highly

problematic since it suggests that eligibility of individuals with TBI and ABI is optional. Eligibility of individuals with brain injury should be made explicit and categorical.

Ninth, the Concept Paper (p. 6) envisions the establishment of a “cross-division workgroup”. It would be preferable to include the SCPD in the workgroup for the following reasons:

A. Individuals with brain injuries are included in the target population. By statute, the SCPD’s Brain Injury Committee is the primary State planning body for individuals with brain injury. See Title 29 Del.C. §8210.

B. The Concept Paper (p. 3) stresses the link between Delaware’s Employment First legislation and the Pathways program. The Employment First Oversight Commission operates under the SCPD. See Title 19 Del.C. §745.

C. The Concept Paper (p. 5) notes that personal/attendant services will be provided by the two existing vendors, Easter Seal and JEVS. The SCPD is the advisory council to the attendant services program. See Title 16 Del.C. §9406.

Tenth, the menu of services is ostensibly oriented towards “physical” impairments. It would be preferable to include some services specific to individuals with brain injury (e.g. cognitive retraining) in consultation with the SCPD BIC. In addition, SCPD recommends that the menu of services be sufficiently inclusive so it would cover self-employment. To the extent that there may be some self-employment which is not considered supported employment (individual) or career exploration, the Department may want to consider adding another category.

Eleventh, the Concept Paper (p. 7) envisions inclusion of “strategies for solving conflict or disagreement”. It would be preferable to explicitly apply the Medicaid “Fair Hearing Practice and Procedures” regulation to the program. See 16 DE Admin Code 5000.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations and recommendations on the proposed regulation.

cc: Mr. Stephen Groff
Mr. Bill Love
Ms. Jane Gallivan
Mr. Dan Madrid
Mr. George Meldrum
Ms. Deborah Gottschalk
Mr. Brian Hartman, Esq.
Employment First Oversight Commission
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

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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. [REDACTED], a minor

DCIS No.:
5000703852

Appearances: Marybeth Putnick, Disabilities Law Program, Community Legal Aid Society, Inc., Counsel for the Claimant
[REDACTED], 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, Witness¹

I

A. G. [REDACTED] (sometimes hereinafter the "claimant"), through counsel and her parent A. [REDACTED] 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. [redacted] 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 Program², the Medicaid Program under Title XIX of the Social Security Act, the "OMB" Program³ 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 capitated⁵ 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. [redacted] is a third party beneficiary of a contract between First State and the Division of Social Services. She is a four-year-old

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 Act⁸. 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.

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 a 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 22 2000
POSTED

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 school, and medical services for evaluation and diagnostic purposes only.³

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 (IEP) 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 physicians' 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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INFORMATION

Citizen Participation

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2100 Eligibility Criteria

1.0 The Division of Developmental Disabilities Services provides services to those individuals with a developmental disability who meet all of the following criteria:

1.1 citizen or a lawful alien of the United States;

1.2 a resident of the State of Delaware;

1.3 a disability/disorder attributed to one or more of the following:

1.3.1 Mental Retardation; defined as a significant generalized limitation in intellectual functioning. Significant generalized limitation in intellectual functioning is defined as IQ scores approximately two standard deviations below the mean. (American Association on Intellectual and Developmental Disabilities; Classification Manual, 2002); and/or

1.3.2 Autistic Disorder (299.00; American Psychiatric Association; Diagnostic & Statistical Manual - IV, 1994); and/or

1.3.3 Asperger's Disorder (299.80; American Psychiatric Association; Diagnostic & Statistical Manual - IV, 1994); and/or

1.3.4 Prader-Willi Syndrome (documented medical diagnosis; World Health Organization; International Classification of Diseases - 9); and/or

1.3.5 Brain injury or neurological condition related to mental retardation that meets: a) a significant generalized impairment in intellectual functioning (defined in 1.3.1); b) significant limitations in adaptive behavior functioning (defined in 1.4); and c) originates before age 22 (defined in 1.5);

1.4 significant limitations in adaptive behavior functioning;

1.4.1 Significant limitations in adaptive behavior functioning is defined as performance that is, at least two standard deviations below the mean of either:

1.4.1.1 Score on a standardized measure of conceptual, social, or practical skills; or

1.4.1.2 Overall score on a standardized measure of conceptual, social and practical skills

1.5 the disability originates before age 22;

1.6 Any individual who is receiving services on the effective date of these regulations who meets the requirements of 1.1 and 1.2 of this section and meets either the requirements of the regulations under which the individual initially established eligibility or the requirements of 1.3 through 1.5 shall be deemed eligible for services.

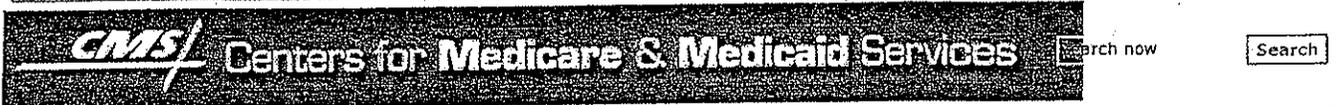
2.0 Intellectual functioning, adaptive behavior functioning, Autistic Disorder, and Asperger's Disorder shall be established and based on the use of standardized assessment instruments accepted by the Division.

4 DE Reg. 228 (07/01/00)

11 DE Reg. 1237 (03/01/08)

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Details for: CMS ISSUES FINAL RULE TO EMPOWER MEDICAID BENEFICIARIES TO DIRECT PERSONAL ASSISTANCE SERVICES

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For Immediate Release: Monday, September 29, 2008

Contact: CMS Office of Public Affairs
202-690-6145

CMS ISSUES FINAL RULE TO EMPOWER MEDICAID BENEFICIARIES TO DIRECT PERSONAL ASSISTANCE SERVICES

A final rule that would allow more Medicaid beneficiaries to be in charge of their own personal assistance services, including personal care services, instead of having those services directed by an agency, was announced today by the Centers for Medicare & Medicaid Services (CMS).

The rule, on display today at the *Federal Register*, guides states who wish to allow Medicaid beneficiaries who need help with the activities of daily living to hire, direct, train or fire their own personal care workers. Beneficiaries could even hire qualified family members who may already be familiar with the individual's needs to perform personal assistance (not medical) services.

"This new plan would give Medicaid beneficiaries significant freedom to determine how their personal assistance services are delivered and by whom," said Kerry Weems, CMS acting administrator. "As health care is not simply an economic transaction, this plan represents a fundamental shift that restores a person's ability to improve their overall health by taking greater control of his or her own decisions," Weems said.

If a state adopts a self-directed personal assistance services state plan option, beneficiaries could receive a cash allowance to hire their own workers to help with such activities as bathing, preparing meals, household chores and other related services that help a person to live independently. Allotments could also be used to purchase items that help foster independence such as a wheelchair ramp or microwave oven. The beneficiaries also have the option to have their cash benefit allotment managed for them.

The rule would put into place a provision of the Deficit Reduction Act of 2005 that allows states to elect a state plan option to provide care in ways that previously required waivers of existing Medicaid laws. Such waivers are subject to certain budgetary requirements and are temporary in nature.

Before a state could request this change to its state plan, it must have an existing personal care services benefit, or be operating a home or community-based services waiver program.

Enrollment in this new state plan option is voluntary and the state must also provide traditional agency-delivered services if the beneficiary wishes to discontinue self-directed care.

States choosing this option must have necessary quality assurances and other safeguards in place to assure the health and welfare of participants. States must also furnish sufficient information, training, counseling and assistance to participants in order to help them effectively manage their budgets and their personal assistance services.

The notice of final rule will be published in the October 3, 2008, issue of the *Federal Register*. The final rule will be effective November 3, 2008.

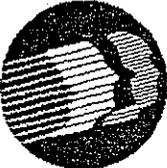
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- 6.1.2.2 Securing and maintaining a checking account to be used for payroll related items
- 6.1.2.3 Filing and maintenance of payroll records required for payroll and tax preparation, as related to attendant employees
- 6.1.2.4 Discussing appropriate employee/employer relationships, including those cases where the employee is also a relative
- 6.2 The participant will:
 - 6.2.1 Be responsible for all employment functions of the attendant including, but not limited to:
 - 6.2.1.1 Conduct hiring interviews for attendants.
 - 6.2.1.2 Supervise and direct attendant in job functions
 - 6.2.1.3 Secure and maintain a checking account to be used for payroll related items
 - 6.2.1.4 Maintain acceptable documentation for payroll and tax filing
 - 6.2.1.5 Complete payroll related tax preparation and filings in a timely manner
 - 6.2.2 Participant may accept or reject attendants referred to them by a provider agency
 - 6.2.2.1 In the event the provider is unable to supply attendant(s) that are acceptable to a participant, the participant may be offered technical assistance to assess the participant's rationale for rejecting all attendant(s) and/or be referred to another provider agency.
 - * 6.2.2.2 Participants are provided the option of hiring a relative or spouse as their paid attendant. A relative, including spouse is considered a paid employee and therefore subject to the same requirements as employees referred by the agency. Individual withholding and tax filing for relatives employees must be performed in compliance with current Federal and State Payroll laws.
- 6.3 Employees must be age 18 or above
 - 6.3.1 The hiring of a minor may be considered on a case-by-case basis and prior approval by DSAAPD is required.
 - 6.3.1.1 The employment of a minor employee is subject to Child Labor Laws and related rules and policies.
 - 6.3.1.2 *Care must be exercised if service is provided by a minor, as they are limited to hours and times they are permitted to work, as outlined in Child Labor Laws and related rules and policies.*
- 6.4 Participants and the provider agency shall share in the responsibility for obtaining attendants when service hours become difficult to fill.
- 6.5 The use of flexed hours within the same pay period is permitted. No hours can be "borrowed" or "advanced" in anticipation of paying them back through flexing at a later date.
- 6.6 Additional short term attendant service hours may be authorized for participants if determined eligible by the DSAAPD Case Manager, and if funding permits