



DISABILITIES LAW PROGRAM

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MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory Initiatives

Date: November 2, 2012

I am providing my analysis of six (6) regulatory initiatives in anticipation of the November 8 meeting. Given time constraints, the commentary should be considered preliminary and non-exhaustive.

1. DMMA Final Program of All Inclusive Care for Elderly (PACE) Reg [16 DE Reg. 532 (11/1/12)]

The SCPD and GACEC commented on the proposed version of this regulation in August, 2012. A copy of the SCPD's August 23, 2012 memo is attached for facilitated reference. The Division of Medicaid & Medical Assistance has now adopted a final regulation incorporating three (3) amendments prompted by the commentary.

First, the Councils identified some "tension" between CMS guidance (indicating that 7% of PACE participants nationwide are nursing home residents) and the proposed DMMA eligibility standard (requiring the participant to be living in the community). The Councils inferred that DMMA intended to require an initial applicant for PACE to be living in the community while allowing continued participation if the applicant subsequently became a nursing home resident. DMMA responded that the Councils' inference was accurate. It added two (2) clarifying amendments. At 534.

Second, the Councils objected to an authorization to terminate eligibility based on even inadvertent and minor non-compliance with a plan of care. DMMA declined to effect an amendment since based on the attached federal regulation, 42 C.F.R. §460.164. The State standard (§10.b) is "similar" to 42 C.F.R. §460.164(b)(2). However, the federal regulation is more "protective" of participants in at least two (2) ways:

A. The federal regulation adopts the term “consistently refuses to comply” while DMMA adopts the term “is consistently non-compliant”. The DMMA term would cover inadvertent non-compliance (e.g. person consistently forgets to take medications) while the federal regulation (requiring “refusal”) would not. A person may have decision-making capacity but still be forgetful or have limitations rendering the non-compliance inadvertent.

B. The federal regulation includes the following additional standard requiring the PACE organization to document efforts to resolve the non-compliance prior to discharge:

(c) Documentation of disruptive or threatening behavior. If a Pace organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant’s medical record:

- (1) The reasons for proposing to disenroll the participant.
- (2) All efforts to remedy the situation.

[emphasis supplied] The DMMA regulation completely omits this safeguard!

Third, the Councils objected to the following basis for involuntary termination from the program: “engages in disruptive, threatening or non-compliant behavior which jeopardizes his or her safety or the safety of others.” The Councils cited CMS and HHS OCR guidance requiring programs to accommodate disabilities rather than simply terminating eligibility. For example, OCR held that the following Delaware regulation violated federal law: “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.” DMMA once again declined to effect an amendment based on its belief that its standard conforms to the attached federal regulation, 42 C.F.R. §460.164. At 535. This is inaccurate. The federal regulation includes the following caveat that the PACE provider assess whether the non-compliance is related to disability:

(d) Noncompliant behavior.

- (1) A PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant’s behavior jeopardizes his or her health or safety, or the safety of others.

42 C.F.R. §460.164(d)

The DMMA regulation omits this safeguard, i.e., it does not require consideration of the relationship between the behavior and the individual’s disability!

Fourth, the Councils requested clarification of whether assisted living services are part of the PACE benefit package. DMMA clarified that they are part of the PACE benefit package.

Fifth, the Councils recommended that the regulation identify the application of the DMMA hearing process to appeals under the PACE program. DMMA agreed and inserted a conforming reference.

I recommend that the Councils issue a “thank you” communication to DMMA for considering the August commentary and effecting some amendments conforming to the commentary. However, the Councils should affirmatively request regulatory amendments based on Pars. “Second” and “Third” above. The request could be shared with the DHSS Secretary, DHSS Chief Policy Advisor, DSAMH Director, DSAAPD Director, and AARP.

2. DMMA Prop. ICF/MR and LTC Facility Reimbursement Regulation [16 DE Reg. 517 (11/1/12)]

The Division of Medicaid & Medical Assistance proposes to amend its Medicaid State Plan by changing the payment methodologies for non-public ICF/MRs.

I have the following observations.

First, it appears that the State “rolled back” payment rates for non-public facilities in 2009 to the rate in effect on December 31, 2008. It is now proposing to exempt private ICF/MRs from that “roll back” for services rendered after August 1, 2012. The State projects that this will result in “leveraging” of federal funds. For example, DMMA anticipates the change will result in \$51,723 in increased State payments and \$194,200 in federal payments in SFY14. At 518. I am only aware of one (1) private ICF/MR in Delaware, the Mary Campbell Center. It would ostensibly benefit from the change.

Second, other long-term care facilities subject to the “roll back” will receive additional funds based on a “Quality Assessment Rate Adjustment. That adjustment is authorized by S.B. No. 227 signed by the Governor on June 28, 2012. The Councils commented on the subsequent regulation defining eligibility for the adjustment. See 16 DE Reg. 38 (July 1, 2012) (proposed); and 16 DE Reg. 309 (September 1, 2012) (final).

In assessing comments, the Councils may be influenced by competing considerations. On the one hand, providing more funds to facilities may result in higher quality of care and an incentive to accept “Medicaid” patients. On the other hand, some may question whether the extra payments may undermine the “movement” towards promoting community-based service options. Given the enactment of S.B. No. 227, and the leveraging of federal funds, I recommend a qualified endorsement of the regulation.

3. DOE Proposed Early Childhood Teacher Regulation [16 DE Reg. 488 (11/1/12)]

The Professional Standards Board and DOE propose to adopt one change to the “Exceptional Children Special Education Teacher” regulation, 14 DE Admin. Code 1571. I have the following observations.

Literally, the current regulation (§1.1) recites that the “Special Education Teacher” certification is required to teach grades K-12. The amendment clarifies the existence of an exception, i.e., an individual with an “Early Childhood Exceptional Children Special Education” certification (14 DE Admin Code 1570) may qualify as a special education teacher in grades K-2. An educator with the “Exceptional Children Special Education Teacher” certification can teach in grades K-12 so there is “overlap” with the “Early Childhood Exceptional Children Special Education” certification which covers grades K-2.

I did not identify any concerns with the proposed change which appears to be a “housekeeping” measure. I recommend endorsement.

4. DOE Prop. Teacher of Students with Autism/Severe Disabilities Reg. [16 DE Reg. 489 (11/1/12)]

The Professional Standards Board and DOE propose to adopt a wholly revised certification regulation entitled “Teacher of Students with Autism or Severe Disabilities” codified at 14 DE Admin Code 1573. I have the following observations.

First, in §2.2, the definitions of “autism”, “intellectual disability”, and “severe intellectual disability” merit revision based on the following:

A. The multiple references to Subparts A and D make no sense. These subparts do not appear in the cited regulations.

B. The definitions are imprecise and confusing. For example, reciting that “autism” means a disability as defined in 14 DE Admin Code 922 and 925 literally means autism includes any and all disability classifications (e.g. ED; LD; PI). The same deficiency applies to the definitions of “intellectual disability” and “severe intellectual disability”. For an alternate approach, see 14 DE Admin Code 608, §1.0, definitions of “crime”, “terroristic threatening”, and “violent felony”. Based on the latter analogy, it would be preferable to consider the following amendments:

“Autism” shall have the same meaning as provided in 14 DE Admin Code 922, §3.0 and 14 DE Admin Code 925, §6.6.

“Intellectual disability” shall have the same meaning as provided in 14 DE Admin Code 922, §3.0 and 14 DE Admin Code 925, §6.12.

“Severe intellectual disability” shall have the same meaning as provided in 14 DE Admin Code 925, §6.12.

Second, the regulation substitutes “severe intellectual disability” for the current term, “severe disabilities” or “severe developmental disabilities”. See superseded version at 490-491. There were no definitions of these terms in the regulation. The latter terms would not be limited to “mental retardation” or “intellectual disability”. It is unclear if the terms “severe disabilities” and “severe developmental disabilities” were interpreted, in practice, to only cover children with severe mental retardation/severe intellectual disability, i.e. those with an I.Q. of 35 or less. For example, does the current regulation also cover children with moderate intellectual disability (formerly moderate mental retardation)? The bottom line is that the regulation may be adopting narrower criteria which merits substantive analysis rather than simply viewing the language change as benign and non-substantive.

Third, there is some tension between the proposed regulation and 14 DE Admin Code 922, §3.0, definition of “highly qualified special education teachers”, Par. 2.0. The latter regulation restricts “highly qualified” teachers to those with “State certification as a special education teacher”. Literally, this would be limited to educators certified under the special education teacher standard, 14 DE Admin Code 1571, to the exclusion of teachers certified under 14 DE Admin Code 1573-1575. The DOE may wish to consider amending Part 1571 for consistency.

Fourth, the addition of “APA” coursework (§4.1.2.1.4) merits endorsement.

Fifth, the Councils may wish to inquire about the application of the “Teacher of Students with Autism or Severe Disabilities” certification. As a practical matter, I could not identify in which contexts the certification would be required. There are some general regulatory references to qualified teachers (14 DE Admin Code 923, §56.0; 14 DE Admin Code 922, §3.0, definition of “highly qualified special education teachers”) but I could not locate any standards which definitively address when a teacher would require this particular certification.

I recommend sharing the above observations with the Professional Standards Board, DOE, SBE, and Autism DE.

5. DOE Proposed Special Education Director Certification Reg. [16 DE Reg. 506 (11/1/12)]

The Professional Standards Board and Department of Education propose to revise the qualifications for the Special Education Director certification.

The most significant change is in §4.2.

First, the current standard (§3.2) requires some combination of three (3) years of teaching or working with exceptional children. This is increased to five (5) years in the proposed regulation.

Second, the current regulation “counts” three (3) years of “administrative experience with children with disabilities”. This is omitted from the current regulation. It is unclear if this represents an intentional restriction or if DOE views administrative experience to be generally subsumed under “working with exceptional children.” The change does create some ambiguity.

Third, the current regulation (§3.2) specifically “counts” work experience by certified school psychologists, speech pathologists, and audiologists. The proposed regulation deletes the references.

The APA envisions identification of the substance and issues presented by proposed regulations. See Title 29 Del.C. §10115(a)(1). This regulation contains only the following cryptic statement: “It is necessary to amend this regulation in order to upgrade the requirements’ rigor and to build upon the other amended administrator regulations.” This imparts little context to explain the DOE’s intent in proposing the changes.

I recommend issuing confirmation that the Councils reviewed the regulation and have no comments apart from recommending that future proposed regulations include more specifics on the rationale for changes.

6. DOE Prop. Teacher of Students Who Are Deaf or HOH Cert. Reg. [Pre-publication Draft]

The Director of Statewide Programs for the Deaf, Hard of Hearing and Deaf-Blind forwarded the above draft regulation to the SCPD, GACEC, and DDC on October 31, 2012.

The Director characterized the following as the “biggest impacts”:

1. specific coursework required to obtain deaf ed certification for folks who are not from a deaf ed. teacher prep program (there are lots of online/hybrid programs that provide these classes). Please note that no particular “Language” course is required - just a course in “visual/gestural communication” (ASL could fit here, but there are other courses too) and auditory language development (this is a speech course);
2. There is an 18 month window for all individuals who teach dhh students - as their primary assignment to have this certification. This matches the autism regulation.

I have the following observations.

First, the template for the regulation matches that of the recent regulations proposed by the Professional Standards Board and DOE. Compare proposed Teacher of Students with Autism or Severe Disabilities, 16 DE Reg. 489 (November 1, 2012) (analyzed above). However, there is a major difference. Other regulations contain a “grandfather” provision. See, e.g., 16 DE Reg. 489, 493, §5.0 (Past Certification Recognized). The draft regulation does not contain a “grandfather” provision. Rather, §1.0 requires compliance with the new standards within eighteen months:

Eighteen (18) months from the effective date of this regulation, this certification shall be required for all educators within the Delaware public school system whose primary assignment is teaching children who are deaf or hard of hearing.

Assuming the Councils would support the ostensibly enhanced standards, providing only 18 months to complete the required twenty-one (21) credits (§4.2) is manifestly too short a period. I recommend promoting a longer time period.

Second, I question whether three (3) credits in ASL (§4.2.8) is sufficient to provide proficiency for middle and high school level instruction in which complicated subjects (Algebra; Calculus) are addressed.

Subject to the disclaimer that I am not an expert on education of students who are deaf or hard of hearing, I did not identify any other concerns.

Attachments

8g:legreg/1112bils
F:pub/bjh/legis/p&l2012/1112bils



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MEMORANDUM

DATE: August 23, 2012

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

FROM: Daniese McMullin-Powell, ^{DMMA/CIT} Chairperson
State Council for Persons with Disabilities

RE: 16 DE Reg. 170 [DMMA Proposed PACE Regulation]

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 establish enrollment standards for the Program for All Inclusive Care for the Elderly (PACE) in Delaware. The proposed regulation was published as 16 DE Reg. 170 in the August 1, 2012 issue of the Register of Regulations. SCPD has the following observations.

First, the key eligibility standards are compiled in §5. There is some "tension" between §5 and §9 in the context of nursing home residency. The CMS document indicates that 7% of PACE enrollees live in nursing homes. Section 9 recites as follows:

9. Nursing facility services are part of the PACE benefit package.

The PACE Organization must notify the Division of Medicaid and Medical Assistance (DMMA) eligibility worker of the individual's placement in a nursing facility.

The PACE individual is not required to contribute to the cost of their care while in a nursing facility.

Thus, the CMS guidance and §9.0 suggest that residents of nursing homes may be eligible for the program. However, §5 requires, as a matter of eligibility for enrollment, that the applicant "(b) living in the community." SCPD infers that an individual must be in the community upon initial enrollment but that "continued eligibility" is not affected by post-enrollment nursing home residency. It would be helpful if DMMA clarified this aspect of eligibility.

Second, §10 b. contains the following justification for involuntary termination from the program:

Has decision making capacity and is consistently non-compliant with the individual plan of care and enrollment agreement, which may impact the participant's health and welfare in the community;...;

This section would literally authorize termination for recurrent "minor/inconsequential" non-compliance with "minor/inconsequential" impact on health and welfare. Providers have a financial incentive to terminate eligibility of "expensive" individuals and it would be preferable to deter involuntary termination in the absence of significant non-compliance. There is also no requirement that the non-compliance be "wilful" rather than inadvertent. For example, an elderly individual's plan may contemplate self-administration of medications. Due to memory deficits, the individual may periodically forget to take medications which affect the individual's welfare. Under a literal reading of the regulatory standard, the individual could be terminated from the program based on consistent non-compliance impacting health. Consider the following substitute:

Has decision making capacity and is wilfully and consistently non-compliant with material components of the individual's plan of care and enrollment agreement which may significantly impact the participant's health and welfare in the community;...

Third, §10.b. contains the following additional justification for involuntary termination from the program:

Engages in disruptive, threatening or non-compliant behavior which jeopardizes his or her safety or the safety of others;...

Individuals with Alzheimer's, dementia, Tourette's or TBI may exhibit such behavior as a symptom of disability. Terminating their eligibility for symptoms of disability would violate §504 and the ADA. CMS requires programs to provide accommodations to participants with disabilities, not "dump" them. Cf. attached CMS Medicaid Director Guidance (July 29, 1998) and CMS Medicaid Director Guidance (May 10, 2010). See also attached October 11, 1985 HHS OCR LOF to Delaware DHSS which held the following regulation violated §504:

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.

OCR commented as follows:

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. ...It is our preliminary determination, based on 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).

Rather than authorizing termination from the program, enrollees manifesting such behavior due to disability should be considered for specialized treatment. See, e.g., 16 DE Admin Code 3225, §§5.5, 5.12 and 7.0; and 16 DE Admin Code 3201, §5.6. Consider the following substitute:

Has decision making capacity and wilfully engages in disruptive, threatening or non-compliant behavior which is not symptomatic of disability and which jeopardizes his or her safety or the safety of others;...

Fourth, it is unclear if “assisted living” services are part of the PACE benefit package. Compare §9.0. This could be clarified. Assisted living settings are required to be “homelike” (16 DE Reg. 3225, §3.0 (definition of “homelike”) and may be less restrictive settings than nursing facilities.

Fifth, the CMS document recites as follows: “If you disagree with the interdisciplinary team about your care plan, you have the right to file an appeal.” The DMMA regulation omits any reference to the right to a hearing to contest denial of program eligibility (§5.0); involuntary termination from the program (§10.0); and disagreements about the plan of care. It would be preferable to clarify that 16 DE Admin Code 5000 applies.

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

cc: Ms. Rita Landgraf
Ms. Rosanne Mahaney
Mr. Brian Posey
Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

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42 CFR 460.164 - Involuntary disenrollment.

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§ 460.164

Involuntary disenrollment.

(a) **Reasons for involuntary disenrollment.** A participant may be involuntarily disenrolled for any of the following reasons:

- (1) The participant fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.
- (2) The participant engages in disruptive or threatening behavior, as described in paragraph (b) of this section.
- (3) The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.
- (4) The participant is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible.
- (5) The PACE program agreement with CMS and the State administering agency is not renewed or is terminated.
- (6) The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

(b) **Disruptive or threatening behavior.** For purposes of this section, a participant who engages in disruptive or threatening behavior refers to a participant who exhibits either of the following:

- (1) A participant whose behavior jeopardizes his or her health or safety, or the safety of others; or
- (2) A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.

(c) **Documentation of disruptive or threatening behavior.** If a PACE organization proposes to disenroll a participant who is disruptive or threatening, the organization must document the following information in the participant's medical record:

- (1) The reasons for proposing to disenroll the participant.
- (2) All efforts to remedy the situation.

(d) **Noncompliant behavior.**(1) A PACE organization may not disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the participant, unless the participant's behavior jeopardizes his or her health or safety, or the safety of others.

- (2) For purposes of this section, noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments.

(e) **State administering agency review and final determination.** Before an involuntary disenrollment is effective, the State administering agency must review it and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.