



DISABILITIES LAW PROGRAM

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MEMORANDUM

To: SCPD Policy & Law Committee
From: Brian J. Hartman
Re: Legislative and Regulatory Initiatives
Date: August 6, 2013

I am providing my analysis of twelve (12) legislative and regulatory initiatives in anticipation of the August 8 meeting. Given time constraints, the commentary should be considered preliminary and non-exhaustive.

1. DMMA Final Diamond State Health Plan Renewal Notice [17 DE Reg. 225 (8/1/13)]

The SCPD and GACEC submitted comments on the proposed renewal of the Diamond State Health Plan (DSHP) waiver in May, 2013. The Division of Medicaid and Medical Assistance has now acknowledged the comments, clarified some aspects of the waiver, and amended a single typographical error. The Division's July 24 memo containing the SCPD's comments and DMMA's response is attached for facilitated reference. I have earmarked recommendations for Council follow-up with underlining.

First, the Councils noted an inconsistency in DMMA documents concerning the length of the renewal being sought. DMMA acknowledged the discrepancy and clarified that it is requesting a five (5) year extension.

Second, the Councils noted that the DPMHS was identified as a distinct MCO under the original DSHP and that a recital that "extended mental health benefits are covered under the traditional Medicaid system" overlooks the role of DPMHS. DMMA responded that the DPMHS is not a distinct MCO while acknowledging that it does "provide the extended mental health benefits for children enrolled in the DSHP requiring more than the identified threshold of services."

Third, the Councils recommended substitution of "through" for "thought" on p. 7. DMMA corrected the reference.

Fourth, the Councils strongly objected to discontinuation of the State MCO, Diamond State Partners. DMMA responded that covering services through the State MCO is not cost-effective and that the “CMS requirement of ‘choice’ is satisfied as long as the State contracts with two MCOs.” The Councils may wish to consider submission of commentary directly to CMS sharing concerns in this context and specifically request that CMS not grant DMMA the authority to operate with a single MCO for up to 15 months if one MCO withdraws. See SCPD’s italicized commentary at p. 3.

Fifth, the Councils observed that they had previously shared concerns about lack of specialized expertise among case managers. DMMA responded that case manager standards were previously revised based on Council input and that “all case managers must have knowledge or experience in: ...(t)he needs and service delivery system for all populations in the Case Manager’s caseload”. DMMA also recites that new case managers receive an orientation and training on ABI. It would be interesting to assess how the MCOs implement the requirement that case managers have expertise in “the needs and service delivery system for all populations in the Case Manager’s caseload”. The Councils may wish to research whether the MCOs use “generic” case managers or specialized case managers for subpopulations (e.g. children versus adults).

Sixth, the Councils recommended expansion of the services menu to include adult dental services. The Division responded that “there is no funding available to expand coverage to the adult population.”

Seventh, the Councils questioned “steering” of participants in the same family to a single MCO. DMMA responded that enrollment of all family members in a single MCO is intended to result in “better navigation of the healthcare system and provider availability”. I am at a loss to identify any enhancement in “provider availability” based on steering all family members to a single MCO. Each family member may have specialty providers who are only enrolled with one MCO or the other. “Provider availability” would be enhanced if “steering” were not utilized.

Eighth, the Councils observed that the following provision “merits revision”: “QII lead by DMMA includes participants from MCOs, other State agencies as well as the EQRO.” DMMA replied: “We cannot respond to this comment because we do not know what revisions the commenter wants.” This is an “odd” response. The Councils would be hard-pressed to suggest a discrete revision to a sentence which makes no sense. Query what is a “QI lead by DMMA”.

Ninth, the Councils recommend inclusion of more specific provider satisfaction levels. The Division responded that specifics are included in attachments.

Tenth, the Councils noted that the restriction on changing MCOs once annually should be subject to exceptions for cause. DMMA responded that exceptions are allowed for “good cause” consistent with 42 CFR 438.56. I am attaching a copy of the regulation for facilitated reference.

Eleventh, the Councils questioned the accuracy of the following provision: “DSHP applicants are always approved retroactively to the first of the month in which they apply for coverage if they meet all Medicaid qualifying criteria.”. DMMA responded that its current waiver allows it to initiate eligibility at a later date, i.e., upon enrollment with an MCO. However, “DMMA proposes to begin providing medical services to all applicable populations beginning with their month of application.”

Twelfth, the Councils noted that a DMMA table establishes a benchmark for member satisfaction with MCOs of “good” and “very good”. The Council recommended identifying other categories (e.g. poor, fair, excellent) since the results could ostensibly be skewed by adopting only variations of favorable categories. DMMA rejected the recommendation without explanation.

Thirteenth, the Councils noted that few appeals of MCO decisions have occurred and recommended that the notice forms include contact information about the availability of free legal assistance through CLASI. DMMA rejected the recommendation. I recommend that the Councils reiterate this recommendation in communication to the DHSS Secretary and include, for contrast, the attached excerpt from the revised July, 2013 DDDS Waiver and sample DMMA/DSS notice of right to fair hearing, both of which explicitly promote referrals to CLASI.

Fourteenth, the Councils endorsed the inclusion of individuals in the Medicaid Workers with Disabilities program in the DSHP+ waiver.

I recommend that the Councils consider follow up consistent with the underlined recommendations.

2. DOE Final Administrator Appraisal Process Repeal Regulation [17 DE Reg. 224 (8/1/13)]

The SCPD and GACEC commented on the proposed version of this regulation in June, 2013. A copy of the SCPD’s June 24 letter is attached for facilitated reference. The Councils endorsed the initiative which essentially repealed a superseded set of regulations as a “housekeeping” measure. The Department of Education has now acknowledged the endorsements and adopted a final order repealing the outdated regulation.

I recommend no further action.

3. DOE Final Teacher Appraisal Process Repeal Regulation [17 DE Reg. 204 (8/1/13)]

The SCPD and GACEC commented on the proposed version of this regulation in June, 2013. A copy of the SCPD’s June 24 letter is attached for facilitated reference. The Councils endorsed the initiative which essentially repealed a superseded set of regulations as a “housekeeping” measure. The Department of Education has now acknowledged the endorsements and adopted a final order repealing the outdated regulation.

I recommend no further action.

4. DOE Final Specialist Appraisal Process Repeal Regulation [17 DE Reg. 214 (8/1/13)]

The SCPD and GACEC commented on the proposed version of this regulation in June, 2013. A copy of the SCPD's June 24 letter is attached for facilitated reference. The Councils endorsed the initiative which essentially repealed a superseded set of regulations as a "housekeeping" measure. The Department of Education has now acknowledged the endorsements and adopted a final order repealing the outdated regulation.

I recommend no further action.

5. DOE Final Specialist Appraisal Process Revision Reg. [17 DE Reg. 216 (8/1/13)]

The SCPD and GACEC commented on the proposed version of this regulation in June, 2013. A copy of the SCPD's June 24 letter is attached for facilitated reference. The Department of Education also received comments from the DSEA.

The Department has now adopted a final regulation with only minor amendments..

First, the Councils expressed concern that the revisions weakened the appraisal process. The Councils provided the following examples: 1) districts and charter schools were being authorized to disregard their choice of four (4) of eighteen (18) appraisal components; 2) the number of observations of novice specialists was being reduced; and 3) improvement plans would no longer be required for specialists with an "unsatisfactory" rating during an observation. The DOE did not address each of these examples. Instead, it generally opined that "the regulation, taken as a whole, provides deeper, more focused opportunities for educator appraisal and continues to develop the system with stronger alignment to student growth results (Component V) and now also includes a required emphasis on the educator evaluation rubrics that had not existed heretofore." At p. 216.

Second, the Councils endorsed an increase in the number of "unannounced" versus "announced" observations of specialists who have earned a rating of "highly effective" or "effective". The DOE did not comment on the endorsement.

Third, the Councils recommended capitalizing the word "evaluator" in §8.4, second sentence. The final regulation reflects the capitalization although it is not earmarked with brackets as required by §2.4.4 of the Register's Delaware Administrative Code Drafting and Style Manual.

Since the regulation is final, I recommend no further action.

6. DOE Final Teacher Appraisal Process Revision Reg. 206 [17 DE Reg. (8/1/13)]

The SCPD and GACEC commented on the proposed version of this regulation in June, 2013. A copy of the SCPD's June 24 letter is attached for facilitated reference. The Department of Education also received comments from the DSEA.

The Department has now adopted a final regulation with only minor amendments..

First, the Councils expressed concern that the revisions weakened the appraisal process. The Councils provided the following examples: 1) districts and charter schools were being authorized to disregard their choice of four (4) of eighteen (18) appraisal components; and 2) improvement plans would no longer be required for teachers with an “unsatisfactory” rating during an observation. The DOE did not address each of these examples. Instead, it generally opined that “the regulation, taken as a whole, provides deeper, more focused opportunities for educator appraisal and continues to develop the system with stronger alignment to student growth results (Component V) and now also includes a required emphasis on the educator evaluation rubrics that had not existed heretofore.” At p. 206.

Second, the Councils endorsed an increase in the number of “unannounced” versus “announced” observations of teachers. The DOE did not comment on the endorsement.

Third, the Councils recommended capitalizing the word “evaluator” in §8.4, second sentence. The final regulation reflects the capitalization.

Since the regulation is final, I recommend no further action.

7. DOE Prop. State Science Content Standards Regulation [17 DE Reg. 148 (8/1/13)]

The Department of Education proposes to amend its content standards regulation. The DOE envisions adoption of “Next Generation Science Standards”. The NGSS standards were developed in partnership with twenty-six (26) states, including Delaware.

The attached August 5, 2013 News Journal article provides useful background on the initiative. Some Delaware teachers and a DuPont scientist were involved in the development of the standards. The standards include the science of evolution and humans’ effect on global climate change. According to the article, some critics have expressed reservations about the standards. For example, climate change and sea level rise education could potentially affect property values and construction at Delaware beaches. Others decry a perceived loss of local control over standards.

I recommend endorsement. For a small state like Delaware, there is great value in partnering with a large consortium of other states to develop evidence-based standards based on “mainstream” science. This approach also reduces prospects for local political interests attempting to skew standards based on considerations apart from “mainstream” science (e.g. business interests could attempt to suppress student exposure to environmental issues).

8. DOE K-12 Health Education Program Regulation [17 DE Reg. 150 (8/1/13)]

The Department of Education proposes to amend its standards for health education. The current regulation requires students to complete a one half (½) credit course in health education to graduate. First, the proposed regulation would require the course, effective with the 2014-15 school year, to include at least two (2) hours on the following: 1) CPR awareness; 2) use of an Automated External Defibrillator (AED); and 3) organ and tissue donation. Second, the proposed regulation would delete a requirement that “the method(s) used to implement and evaluate the effectiveness of the program” be reported in the District/School Success Plan.

I have the following observations.

Health Education Course Content

First, the regulation is ostensibly partially motivated by three sets of State legislation.

A. H.B. No. 299 from the 146th General Assembly would have required all students to participate in a training program in CPR and use of an AED to be granted a high school diploma. While conceptually “open” to CPR/AED education, the Department of Education expressed reservations about the legislation given the potential for enactment of multiple bill dictating content of instruction in a wide variety of contexts. H.B. No. 299 was tabled in committee on April 26, 2012.

B. The legislation may also be partially motivated by SCR No. 30 which passed the House and Senate in June, 2013. That legislation notes that CPR and AED use can be effective in resuscitating student athletes who are subject to sudden cardiac arrest. The resolution “encourages the state of Delaware to work with the Delaware Interscholastic Athletic Association (DIAA) to explore Sudden Cardiac Arrest education initiatives and alternatives for saving lives such as setting standards for protecting student athletes exhibiting signs of Sudden Cardiac Arrest, and training coaches and officials of interscholastic athletes.”

C. Finally, SCR No. 11 passed the House and Senate in April, 2013. It notes that “in Delaware only 48 percent have placed the organ donor designation on their learner’s permit, driver’s license or state identification card.” It further recites that “in Delaware, the organ transplant list includes 600 people while thousands of others await a tissue transplant...” It encourages education on the importance of organ and tissue donation.

Given the compelling legislative findings on the value of education and training on CPR/AED usage and organ/tissue donation, I recommend endorsement of this aspect of the proposed regulation.

District/School Success Plan Deletion

The second component of the proposed regulation is to delete the current requirement that the methods used to implement and evaluate the effectiveness of the program be included in the district/school success plan. Instead, the “methods” would be shared with the Department of Education upon request. The DOE provides no rationale for this change. It is therefore difficult to assess. I recommend that the SCPD advise the DOE that it is unable to share perspective on this aspect of the regulation given lack of information.

Parenthetically, since the regulation is ostensibly motivated by legislation, the Council could consider sharing a courtesy copy of its commentary to legislators.

9. DMMA/DDDS Proposed HCBS Waiver Amendments [17 DE Reg. 156 (8/1/13)]

The Division of Medicaid & Medical Services and Division of Developmental Disabilities Services propose adoption of some discrete amendments to the current DDDS Medicaid waiver. The changes are itemized at p. 157 and center on authorizing a new waiver service (“group supported employment”); changing the billable unit for day habilitation, pre-vocational services, and supported employment to 15 minutes; and revising the standards for case manager review of progress on the plan of care. Excerpts of the changes are included in the Register of Regulations and details are contained in the full 171-page “Application for a §1915(c) Community-Based Services Waiver” (hereinafter “Waiver”) on the DDDS Website - <http://www.dhss.delaware.gov/ddds/>.

I have the following observations.

First, the current “supported employment” definition contains an exclusion for transportation: “Transportation is not include in supported employment services.” At p. 158. In contrast, the proposed definitions of individual and group supported employment include transportation as an included expense.¹ At pp. 158-159. Although not mentioned by DMMA/DDDS, this change merits endorsement.

Second, the State proposes to revamp its standards for case manager monitoring of progress on plans of care. The current standard requires a direct interview with the client every month. The proposed standard requires monthly “paper” monitoring supplemented by a face-to-face direct interview 4 times/year, 2 of which must be in the client’s home. At p. 159. See also attached p. 91 from Waiver. I identified a few concerns in this context.

A. The “Waiver” still contains references to the old standard. See, e.g., attached p. 92: “The DDDS Case Manager reviews and monitors the implementation of services at least monthly through a direct, person to person meeting and discussion with the participant.”

¹Transportation costs are also included in rates for day programs and pre-vocational services. See attached p. 153 from “Waiver”.

B. The new standards do not literally permit any flexibility. For example, other sections in the Waiver contemplate updating a plan when the participant's needs change (Waiver, attached pp. 85 and 99) and the ELP can require "other progress reports" (Waiver, attached p. 91). Literally, a case manager could view the schedule as a rigid "cap" which cannot be exceeded. Thus, there may be circumstances in which more than four (4) face-to-face interviews are needed annually to address a participant's needs. It would be preferable to clarify that the monthly review protocol is a "minimum" which case managers may exceed.

C. It's unclear what documentation would be analyzed by the case manager conducting a monthly "paper" review. Attendance reports may be available on a monthly basis but would not be informative in the context of progress on ELP vocational goals. See attached p. 156 from Waiver. The Waiver only contemplates submission of vocational work reports on a quarterly, not a monthly basis. See attached p. 91. DHSS could consider either making submission of vocational work reports a monthly requirement or requiring submission of other documentation to allow for meaningful monthly review. For example, the Chimes prepares a detailed monthly vocational report. See attached form.

Third, one of the principal rationales for adopting a 15-minute billable unit for day program, pre-vocational services, and supported employment services is flexibility. DDDS wishes to ensure that participants can engage in combinations of supported employment and pre-vocational services. Authorizing billing in small increments facilitates this approach. However, there is some "tension" between this intended flexibility and language in the Waiver itself. Consider the following recitals:

Day Habilitation services can be provided as a full day or hourly. ...Day habilitation may not be provided to a participant during the same hours that Supported Employment, Work Services or Community Inclusion is provided.

Pre-Vocational services can be provided as a full day or hourly. ... Pre-vocational services may not be provided to a participant during the same hours that Supported Employment, Work Services, or Community Inclusion is provided.

Waiver, pp. 48 and 50 (attached).

Consider a participant who engages in supported employment between 11-11:30 and pre-vocational services between 11:30-12. Using the 15-minute billing increment, the provider could bill 2 units of supported employment and 2 units of pre-vocational services. However, the above language would literally bar such billing. Alternatively, consider a participant who engages in supported employment between 9-11:05 and pre-vocational services between 11:05 - 12:00. The provider could not bill for pre-vocational services for the period 11:05- 12:00 since within the same hour as supported employment. For maximum flexibility, the State could consider revising the above "limiting" language and adopting a "quarter hour" unit akin to that used for behavioral consultative services and nursing consultative services. See attached p. 167 from Waiver. See also attached p. 153: "Small group will be paid in 15 minute billable units." It would simply be less confusing to adopt a "quarter hour" standard than to sometimes refer to "hourly" units (p. 166) and sometimes refer to "15 minute billable units" (p. 153).

Fourth, in a related context, guidance on the 15-minute billable units for behavioral consultative services and nursing consultative services addresses “rounding”:

Units of time 1-8 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

See attached p. 154 from Waiver. I could not locate any analog for “rounding” for 15-minute billable units for supported employment, pre-vocational services, and day programming. Clarification would be preferable.

I recommend sharing the above observations with DMMA and DDDS.

10. DOE Proposed Accelerated Academic Programs Regulation [17 DE Reg. 152 (8/1/13)]

As background, S.B. No. 27 was signed by the Governor on June 30, 2013. It authorizes “academic excellence start-up grants” for public schools and directs the Department of Education to award such grants based on appropriated funds. The DOE is further charged with development of a formula for evaluating grant proposals which must be consistent with “preferences” identified in the legislation. The DOE is now issuing a proposed regulation implementing the bill.

Overall, the proposed regulation is relatively straightforward and logically sequenced. However, I identified the following two (2) concerns:

First, there is an inconsistency between §1.0 (definition of “academic work”) and §2.5. Although the legislation [§3113(b)(3)] authorizes inclusion of “programs on the visual and performing arts”, it does not specifically list “visual and performing arts” in the definition of “academic work” [§3113(d)]. In contrast, the DOE regulation [§1.0, definition of “academic work”] specifically adds “visual and performing arts” to the definition. It then anomalously refers to “visual and performing arts” as outside the definition of “academic work” in §2.5. This discrepancy should be resolved. For example, the DOE could delete the reference from the definition of “academic work” in §1.0. In that case, §2.5 would be apt.

Second, §3.7 authorizes earning up to 6 points for “efficiency of spending” which focuses on the extent to which projects allocate funds to activities “that will directly impact students”. The DOE explicitly stresses that educator professional development is “counted” as an activity directly affecting students. This approach is difficult to justify. Using funds to send teachers to training events should not be a core component of this grant program. The regulatory emphasis on professional development “sends the wrong message” to prospective applicants and could result in dilution of funds more closely linked to “direct impact” on students (e.g. purchase of books and supplies; field trips; guest lecturers; films).

I recommend endorsement of the regulation subject to revisions consistent with the above two (2) concerns.

11. DFS Prop. Residential Child Care & Day Treatment Program Reg. [17 DE Reg. 186 (8/1/13)]

The SCPD and GACEC commented on an earlier version of this proposed regulation. A copy of the June 24, 2013 SCPD memorandum is attached for facilitated reference. The Councils submitted only three (3) comments on the 37-page set of standards. DFS later conducted a teleconference with the DLP and SCPD on related regulations which provided the opportunity for supplemental dialog. DFS has now issued a revised set of proposed regulations.

I have the following observations.

First, consistent with the June 24 commentary, the Division is substituting “regulation” for “requirement” throughout the standards. The Division corrected two references (§§5.11 and 7.11) as recommended by the June 24 commentary.

Second, the Division corrected the reference in §10.4.2 as recommended by the Councils.

Third, the Division did not revise its proposed ban on the presence of any toy in a crib with a sleeping infant in §11.11.2.8.

Fourth, in response to the Councils’ observation that the regulation lacked a definition of “infant”, the Division added a definition of “infant” in §1.3. However, unlike the balance of definitions, DFS did not number the definition of “infant”. The numbering of the definitions runs from Rule 1.01 through Rule 1.42. This observation is part of a larger concern. The Administrative Code Drafting and Style Manual, §3.12, contains the following admonition: “Do not number individual definitions.” Therefore, the Division may wish to consider revising the format of its definitions section.

Fifth, in response to the supplemental dialog among DFS, the SCPD and DLP, DFS is revising its definition of “child” in §1.3. It proposes to delete the inclusion of a person in a facility “who becomes 18 years of age while residing in the facility or participating in the program, and who has not attained the age of 25.” At one time, this was an important safeguard for young adults placed at AdvoServ which had no licensing standards applicable to adults. Since the DLTCRP has adopted regulations covering adult AdvoServ residents, the DFS deletion of overlapping regulations is not as problematic. However, it could prove troublesome for individuals who receive extended DFS services through age 21 consistent with H.B. No. 163. If a covered individual continued residency in a residential child care facility or participated in a day treatment program, the deletion of the above sentence could result in an absence of protections and standards applicable to the individual. DFS should reconsider the deletion.

I recommend sharing the above observations with the Division.

12. Prepublication Draft Speech Language Pathologist Assistant Legislation & Regs. [7/31/13]

On July 31, the Division of Professional Regulation forwarded to the GACEC draft legislation and regulations related to the creation of a new licensure category, speech/language pathology assistants. See attachments. The Division solicited comments by August 16 in anticipation of review by the Board of Speech/Language Pathologists, Audiologists and Hearing Aid Dispensers at its August 20 meeting.

Draft Legislation

The attached draft legislation is relatively short (2 pages) and straightforward.

I have the following observations.

First, the definition of “speech/language pathology assistant” and “supervising speech language pathologist” could be inserted in §3702 of Chapter 37 rather than in a new §3721. Compare Title 24 Del.C. §2002(4)(9) and §2602(7).

Second, §3722(a) disallows anyone from engaging in the practice as a speech/language pathology assistant in Delaware unless licensed under the chapter. The analogous OT enabling legislation [Title 24 Del.C. §2605(d)] contains an exemption for individuals working in federal facilities (e.g. VA hospital). The Division may wish to assess whether an analogous provision should be added to Chapter 37.

Third, §3723(a) (1) requires an applicant to have “received a bachelor’s degree or higher from a speech/language pathology program at an accredited institution.” My impression is that colleges and universities typically confer degrees, not programs within colleges and universities. Query whether someone who has a minor in a bachelor’s level speech/language pathology program but a major in an unrelated field meets the criteria in this subsection. Compare 14 DE Admin Code 1583, §4.1.1.1, which addresses both successful completion of specialized program and acquisition of a particular degree.

Proposed Regulations

First, there is a “disconnect” between the proposed legislation and the regulations. Section 3724(c) requires the Board to address the number of speech/language pathology assistants “and/or clinical fellows” that may be supervised at one time. The regulations address supervision of assistants but not “clinical fellows”. See §6.3.1.2 and §6.8.1.1.

Second, §6.6.4.2 categorically bars a licensed assistant from engaging in the assessment or treatment of patients with feeding/swallowing disorders. Intuitively, if the assistant is working within the view (§6.1.1) of the supervisor, this could be perceived as unduly restrictive. Moreover, there are gradations of risk for feeding/swallowing disorders and the regulation treats anyone with a very mild risk the same as individuals with a moderate-severe risk.

Third, §6.6.4.5 bars an assistant from “making recommendations for additional services”. This is counterintuitive. If an assistant notices an area of need, or believes assistive technology or a particular clinical approach might help a patient, the assistant is literally barred from offering a suggestion to the supervising speech/language pathologist.

I recommend sharing the above observations with the Division.

Attachments

8g:legis/813bils
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JUL 31 2013



**DELAWARE HEALTH
AND SOCIAL SERVICES**
DIVISION OF MEDICAID AND
MEDICAL ASSISTANCE

MEMORANDUM

DATE: July 24, 2013

TO: Kyle Hodges
Director
State Council for Persons with Disabilities

FROM: Sharon L. Summers *Sharon L. Summers*
Social Service Administrator

RE: 16 DE Reg. 1140 [DMMA Proposed Diamond State Health Plan Regulation] – May 1, 2013

Thank you for your recent memorandum regarding the Division of Medicaid and Medical Assistance (DMMA) notice soliciting comments on its proposed renewal of the Diamond State Health Plan (DSHP) waiver. This was published as 16 DE Reg. 1140 in the May 1, 2013 issue of the Register of Regulations. DMMA has considered your comments and responds as follows.

You write,

The notice includes links to a 61-page document [hereinafter "Extension Request"] containing the proposed waiver application and several appendices. The DSHP is the Medicaid managed care program first adopted in 1996. The Extension Request (p. 61) indicates that comments and the DMMA responses will be shared with CMS. SCPD has the following observations.

First, the Public Notice is inconsistent with the "Extension Request". The Notice [16 DE Reg. 1140 (May 1, 2013)] recites that the extension is sought "for an additional three years". In contrast, the Extension Request is for five years. At pp. 4 and 61.

Agency Response: Thank you for pointing out the discrepancy. The Extension Request is correct. DMMA is requesting an extension for five (5) years.

Second, the Division of Prevention and Behavioral Health Services (DPBHS), formerly the Division of Child Mental Health Services, was identified as a distinct MCO under the original DSHP. See attachments. If it still enjoys that status, its role should be described in the Extension Request. The Extension Request (p. 15) indicates that "extended mental health" benefits "are covered under the traditional Medicaid system." To the contrary, my impression is that the DPBHS provides extended

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mental health benefits for children enrolled in the DSHP requiring more than a certain threshold of services.

Agency Response: DPBHS does not operate as a Managed Care Organization specified under the requirements in 42 CFR 438. DPBHS does coordinate and provide the extended mental health benefits for children enrolled in the DSHP requiring more than the identified threshold of services.

Third, on p. 7, the word “thought” should be “through”.

Agency Response: The waiver document has been corrected with the word “through”.

Fourth, effective July 1, 2014, DMMA “plans to terminate the state-operated primary case management entity, Diamond State Partners (DSP).” See Extension Request, p. 12. The DSHP originally had four MCOs. By 2002, it had only one MCO left. See Extension Request, pp. 22-23. Given the need for “choice”, DMMA essentially established a State MCO, Diamond State Partners (DSP). From 2007 to the present, DMMA has had two private MCOs. DMMA implies that enrollment in DSP has declined dramatically due to the attractiveness of the two private MCOs:

DSP was created in July, 2002 when Delaware had only one commercial Managed Care Organization (MCO). However, since 2007, Delaware has had two viable commercial MCOs for member choice. As a result, DSP enrollment has dropped from a high enrollment number of 17,980 in May, 2004 to less than 3,200 currently.

Enrollment Request, p. 12.

In fact, DMMA has discouraged or barred recent enrollment in DSP. In 2011, when the waiver was being modified to create the DSHP+ program, SCPD strongly objected to DMMA’s decision to bar participation of DSP. The Council viewed a choice among only two MCOs as minimal. SCPD also stressed that the State would lose “leverage” in financial negotiations with two MCOs since the MCOs would realize that withdrawal of either MCO could force the State to create a State MCO. DMMA acknowledges this “dynamic” in the current Extension Request (at p. 23): “The decisions of various MCOs to discontinue participation in the DSHP in the past were based largely on their attempts to negotiate exorbitant inflationary increases at contract negotiation time, believing that Delaware would have to accept their terms or discontinue the waiver.” In pertinent part, SCPD’s September 6, 2011 critique (italicized) of the DSHP+ proposal was as follows:

CHAPTER II: PROGRAM DESCRIPTION

Section II.1: This section recites that “(t)he State wishes to have a maximum of two Contractors to provide a statewide managed care service delivery system...”. This is apart from the State-run MCO,

Diamond State Partners (DSP) which DHSS notes is closed to new members. See also §II.3.3. There are multiple “concerns” with this approach.

a. The Division of Prevention and Behavioral Health Services (DPBHS) is an MCO under the DSHP. This is not clarified in this section or elsewhere in the document. Section II.7.6.2.1, which uses outdated

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references to the Division of Child Mental Health Services, does not identify DPBHS as an MCO under the DSHP. Parenthetically, an outdated reference to DCMHS also appears in §9.5.2.

b. Allowing only the 2 current private MCOs to implement the DSHP Plus severely limits participant freedom of choice. The original DSHP had four (4) MCOs - Amerihealth, Blue Cross, First State, and Delaware Care. This provided real competition and an incentive to offer supplemental services (e.g. eyeglasses) to attract participants. Although the current plan authorizes MCOs to offer supplemental services (§§II.7.3.1.a; 7.3.3; and 7.5, final bullet), the prospects for MCOs offering such services are marginal given the non-competitive system adopted by DHSS. The prospects for “conscious parallelism”, “price fixing”, and collusion are enhanced with only 2 MCOs. No RFP was issued to invite competitive bids to serve as an MCO. Moreover, DHSS eschews any negotiating leverage with the 2 approved MCOs which are quite aware of the burden faced by DHSS if 1 of the MCOs withdraws. The Concept Paper contains the following recitation:

(I)n the unlikely event that one MCO should discontinue participation in DSHP Plus, DMMA requests authority to continue mandatory managed care for up to 15 months under a single MCO while DMMA seeks participation from a second qualified MCO.

This undermines the important “choice” feature of the Medicaid program and merits opposition. Moreover, given the history of MCO’s dropping out of the DSHP, the representation that discontinuation of participation by 1 MCO is an “unlikely event” is not realistic. The only reason DHSS established a

State-run MCO was because MCOs cited monetary losses, dropped out of the DSHP, and left only one private MCO.

It would be preferable to include DSP as an MCO implementing DSHP Plus or to issue an RFP to enroll more than 2 private MCOs.

The Council strongly opposes the discontinuation of the DSP. We recommend that DMMA provide satisfaction survey results on DSP to permit comparison with satisfaction survey results from the two private MCOs described at p. 38 of the Extension Request. If satisfaction results for the DSP are high, this would provide additional support for not diminishing “choice” by terminating the DSP.

Agency Response: DMMA appreciates your comments regarding DSP. DMMA endorses freedom of choice. As the commenter points out, however, experience has shown that the small population in Delaware does not support the viability of multiple managed care organizations. We are confident that two managed care organizations effectively and efficiently serve the existing DSHP population without limiting access to services. It is no longer cost-effective to cover services through the State managed program, DSP. Please note that CMS requirement of “choice” is satisfied as long as the State contracts with two MCOs.

Fifth, DMMA describes case management as follows:

DMMA has established minimum case management program requirements and qualifications for case managers. ...Additionally, DMMA requires that each MCO assign one and only one case manager for every member eligible to receive long-term care services.

Kyle Hodges
State Council for Persons with Disabilities
July 24, 2013 – Page 4

Extension Request, p. 15.

The Council has previously shared concerns with case manager-participant ratios under the DSPH+ and the lack of specialized expertise among case managers for distinct subpopulations, particularly TBI.

Agency Response: The DMMA addressed the Councils' concerns previously and revised the case management qualifications to ensure that case managers were not treated as fungible, therefore all case managers must have knowledge or experience in:

1. The needs and service delivery system for all populations in the Case Manager's caseload
2. Newly hired case managers must be provided orientation and training in a minimum of the following areas:
 - a. Case Management techniques for specialty populations, such as individuals with Acquired Brain Injuries.

The MCOs are required to establish a long-term care case management and support coordination program for DSHP Plus members as directed by the State. Coupled with the minimum case management program requirements and qualifications for case managers, these requirements attempt to address the distinct subpopulations such as TBI.

Sixth, the planned expansion of eligibility to individuals with countable income at or below 133% of the FPL merits endorsement. See Extension Report at p. 12. However, it would also be preferable if the benefits menu could be enhanced to cover adult dental services. Such services are currently excluded. See Extension Request at p. 16. Such expansion has some legislative support. See S.B. 56, introduced on April 30, 2013.

Agency Response: Thank you for your endorsement of the expansion. We recognize the importance of offering dental services. However, at this time there is no funding available to expand coverage to the adult population.

Seventh, DMMA indicates that its Health Benefits Manager (HBM) "encourages", members of the same family to select the same MCO. The rationale for such "encouragement" is not disclosed. "Steering" of participants to a single MCO based on the choice of other family members is ostensibly an odd approach. It would be preferable to prioritize other factors, including whether the MCO includes the PCP and specialist used by the participant.

Agency Response: DMMA's decision to encourage family members to select the same MCO is based on the benefits to the family including, but not limited to: better navigation of the healthcare system and provider availability. Participants always have the option to select an alternative MCO within 90 days of enrollment.

Eighth, on p. 29 of the Extension Request, the reference to "QII lead by DMMA" merits revision.

Agency Response: We cannot respond to this comment because we do not know what revisions the commenter wants.

Kyle Hodges
State Council for Persons with Disabilities
July 24, 2013 – Page 5

Ninth, p. 38 of the Extension Request contains the following recital: "Results indicate that provider satisfaction levels during this period 2009 to 2012 are positive in both plans. "This is somewhat cryptic since a 51% satisfaction rating could be viewed as "positive". It would be preferable to provide more specific results. Consistent with the "Fourth" comment above, it would also be useful to include satisfaction statistics for the DSP.

Agency Response: Both attachments "D" and "E" break out specifics for satisfaction levels. Additionally, the QMS provides more details concerning the MCOs' satisfaction levels.

Tenth, the restriction to change MCOs to once annually (Extension Report, p. 60) should be subject to exceptions for cause. Indeed, Attachment "D", which collects client complaints, describes a request to change an MCO since the PCP was no longer enrolled with the current MCO. It should be regarded as "good cause" to switch to an MCO in which the PCP is a participating provider.

Agency Response: "Good Cause" exceptions are incorporated as outlined in 42 CFR 438.56.

Eleventh, the Extension Report, p. 60, recites as follows: "DSHP applicants are always approved retroactively to the first of the month in which they apply for coverage if they meet all Medicaid qualifying criteria". We question the accuracy of this representation. The DLP is currently involved in a case in which DMMA has declined retroactive eligibility to the first of the month in which the applicant applied for coverage. DMMA identifies the first of the month in which the participant enrolls with an MCO as the initial date of coverage. Moreover, the excerpt from the March, 22, 2012 CMS approval of the DSHP identified a concern with 6-8 week delays in initiating Medicaid eligibility for approved applicants.

Agency Response: DMMA appreciates the comment noting that our currently approved 1115 waiver permits the State to begin providing services to certain population groups upon enrollment in an MCO. As part of this waiver renewal, DMMA proposes to begin providing medical services to all applicable populations beginning with their month of application.

Twelfth, Attachment P, Table IV, Goal 4, establishes a benchmark of "number and percent of members who rate their experience of care as 'Good' or 'Very Good'." This could be improved. For example, if the only 2 choices are "Good" and "Very Good", the results are not valid. The other categories in the survey (e.g. poor; fair; excellent) should be identified.

Agency Response: DMMA appreciates and has considered the recommendations expressed and thank you for your comments. However, we have not proposed any changes to the waiver as a result of this comment.

Thirteenth, Attachment P, Table IV, Goal 1, includes a quality measure based on "appeals both pre-service and post-service per 1,000 members". The Councils have expressed concern with the negligible number of appeals of DSHP+ participants. Based on participant descriptions of proposed reductions in services without MCO disclosure of appeal rights, this measure may be of questionable validity. Moreover, it would be preferable if DMMA would honor CLASI's request to require contact information about the availability of free legal assistance in MCO notice forms.

Kyle Hodges
State Council for Persons with Disabilities
July 24, 2013 – Page 6

Agency Response: DMMA appreciates and has considered the recommendations expressed and thank you for your comments. However, we have not proposed any changes to the waiver as a result of this comment.

Fourteenth, consistent with the attachment, we appreciate that individuals under the Medicaid Workers with Disabilities program are included in DSHP+.

Agency Response: Thank you for your comments. DMMA continues to support efforts to move individuals from institutional settings to community based settings.

DMMA is pleased to provide the opportunity to receive public comments and greatly appreciate the thoughtful input given.

Cc: Stephen M. Groff, Director, DMMA

ELECTRONIC CODE OF FEDERAL REGULATIONS**e-CFR Data is current as of July 30, 2013**

Title 42: Public Health
PART 438—MANAGED CARE
Subpart B—State Responsibilities

§ 438.56 Disenrollment: Requirements and limitations.

(a) *Applicability.* The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) *Disenrollment requested by the MCO, PIHP, PAHP, or PCCM.* All MCO, PIHP, PAHP, and PCCM contracts must—(1) Specify the reasons for which the MCO, PIHP, PAHP, or PCCM may request disenrollment of an enrollee;

(2) Provide that the MCO, PIHP, PAHP, or PCCM may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); and

(3) Specify the methods by which the MCO, PIHP, PAHP, or PCCM assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(c) *Disenrollment requested by the enrollee.* If the State chooses to limit disenrollment, its MCO, PIHP, PAHP, and PCCM contracts must provide that a beneficiary may request disenrollment as follows:

(1) For cause, at any time.

(2) Without cause, at the following times:

(i) During the 90 days following the date of the beneficiary's initial enrollment with the MCO, PIHP, PAHP, or PCCM, or the date the State sends the beneficiary notice of the enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.

(iv) When the State imposes the intermediate sanction specified in § 438.702(a)(3).

(d) *Procedures for disenrollment*—(1) *Request for disenrollment.* The beneficiary (or his or her representative) must submit an oral or written request—

(i) To the State agency (or its agent); or

(ii) To the MCO, PIHP, PAHP, or PCCM, if the State permits MCOs, PIHP, PAHPs, and PCCMs to process disenrollment requests.

(2) *Cause for disenrollment.* The following are cause for disenrollment:

(i) The enrollee moves out of the MCO's, PIHP's, PAHP's, or PCCM's service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

(3) *MCO, PIHP, PAHP, or PCCM action on request.* (i) An MCO, PIHP, PAHP, or PCCM may either approve a request for disenrollment or refer the request to the State.

(ii) If the MCO, PIHP, PAHP, PCCM, or State agency (whichever is responsible) fails to make a disenrollment determination so that the beneficiary can be disenrolled within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.

(4) *State agency action on request.* For a request received directly from the beneficiary, or one referred by the MCO, PIHP, PAHP, or PCCM, the State agency must take action to approve or disapprove the request based on the following:

(i) Reasons cited in the request.

(ii) Information provided by the MCO, PIHP, PAHP, or PCCM at the agency's request.

(iii) Any of the reasons specified in paragraph (d)(2) of this section.

(5) *Use of the MCO, PIHP, PAHP, or PCCM grievance procedures.* (i) The State agency may require that the enrollee seek redress through the MCO, PIHP, PAHP, or PCCM's grievance system before making a determination on the enrollee's request.

(ii) The grievance process, if used, must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in § 438.56(e)(1).

(iii) If, as a result of the grievance process, the MCO, PIHP, PAHP, or PCCM approves the disenrollment, the State agency is not required to make a determination.

(e) *Timeframe for disenrollment determinations.* (1) Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCO, PIHP, PAHP, or PCCM files the request.

(2) If the MCO, PIHP, PAHP, or PCCM or the State agency (whichever is responsible) fails to make the determination within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.

(f) *Notice and appeals.* A State that restricts disenrollment under this section must take the following actions:

(1) Provide that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period.

(2) Ensure access to State fair hearing for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment.

(g) *Automatic reenrollment: Contract requirement.* If the State plan so specifies, the contract must provide for automatic reenrollment of a beneficiary who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

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the choice of home or community-based services as an alternative to institutional care or who are denied the service(s) of their choice, or the provider(s) of their choice. DDDS requires a letter indicating the individual's right to a Fair Hearing be sent to the individual and/or their legal guardian.

When an individual applies for services under this waiver, he or she is assessed to determine medical and financial eligibility. Following the eligibility determination process, written correspondence is mailed to this individual related to his or her eligibility to receive services through this waiver. Included in this information is the Fair Hearing notice. Notices of adverse action and the opportunity to request a Fair Hearing, at the time of entrance to the waiver, are maintained in the DDDS Office of Applicant Services.

* The Fair Hearing notice indicates: denial of service, reduction of service, suspension of service, or termination of service can generate a Fair Hearing. The individual has the right to appeal and to be heard in a Fair Hearing if he/she is dissatisfied with the action. The individual must present a written request if he/she wishes to obtain a Fair Hearing. The individual may be represented by legal counsel (referrals are made to Community Legal Aid in instances where private legal counsel is not financially feasible) or other persons of his/her choice at the Fair Hearing. The individual may discuss this action with a member of the agency's staff. Filing a grievance does not interfere with the individual's Fair Hearing rights. The individual's benefits continue during the fair hearing process if the issue in question is not one of state or federal law. If the individual's benefits continue, they may be responsible for repayment, if they lose the Fair Hearing.

In order for Medicaid to continue, the actual receipt of a written request for a Fair Hearing is required within 10 days from the date of the notice/action being disputed. The individual may write directly to the agency or detach a portion of the notice and mail it to his/her local DMMA office.

* Fair Hearing notices accompany notification of all other adverse actions and notify the individual of his/her right to a Fair Hearing. Notices are sent by case managers and/or providers by mail to individual. While not all of these actions are typically carried out in this waiver program, any adverse action, including action related to choice of HCBS vs. institutional service; choice of provider of service; and the denial, reduction, suspension or termination of service would be accompanied by the Fair Hearing notice described above. Case managers assist individuals in pursuing Fair Hearings by assisting the individual with the completion of forms or referrals to Community Legal Aid, as needed.

Documentation concerning Fair Hearing notifications are kept on file by DMMA via the quarterly State Fair Hearing Report.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply.

Yes. The State operates an additional dispute resolution process

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DDDS operates an appeals process for individuals and/or their guardian or advocate to aggrieve any DDDS decision to which satisfactory resolution cannot be reached. DDDS appeals process is a dispute resolution mechanism requested in conjunction with or in addition to a State Medicaid Fair Hearing request. DDDS sends the individual and/or their guardian or advocate a written explanation of the disputed decision, the reason for such and notification of their right to request a DDDS appeal.

Instructions for requesting the DDDS appeal are provided and includes sending the appeals request form (included with the notification letter) to the Appeals Committee Chairperson.

Significant timelines regarding the request for and processing of a DDDS appeals request are as follows:

- 30 days from receipt of adverse notification letter to request an appeal;
- 5 working days from date of receipt of appeal request to schedule the appeal;



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June 24, 2013

Ms. Susan K. Haberstroh
Education Associate
Department of Education
401 Federal Street, Suite 2
Dover, DE 19901

RE: 16 DE Reg. 1253 [Proposed Administrator Appraisal Process Repeal Regulation]

Dear Ms. Haberstroh:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) proposal to repeal *14 DE Admin. Code 108 Administrator Appraisal Process Delaware Performance Appraisal System (DPAS II)*. The proposed regulation was published as 16 DE Reg. 1253 in the June 1, 2013 issue of the Register of Regulations.

DOE regulations include two (2) sets of appraisal standards covering administrators, Part 108 and Part 108A. The latter (Part 108A) version took effect with the 2011-2012 school year. Since the Part 108 standards have been superseded, DOE is repealing them in their entirety. SCPD endorses this "housekeeping" initiative.

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

Sincerely,

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

cc: The Honorable Mark Murphy
Dr. Teri Quinn Gray
Ms. Mary Ann Mieczkowski
Ms. Paula Fontello, Esq.
Ms. Terry Hickey, Esq.
Ms. Ilona Kirshon, Esq.
Ms. Donna Mitchell
Mr. Brian Hartman, Esq.
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16reg1253 doe-admin appraisal process repeal 6-24-13



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June 24, 2013

Ms. Susan K. Haberstroh
Education Associate
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RE: 16 DE Reg. 1234 [Proposed Teacher Appraisal Process Repeal Regulation]

Dear Ms. Haberstroh:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) proposal to repeal *14 DE Admin. Code 106 Teacher Appraisal Process Delaware Performance Appraisal System (DPAS II)*. The proposed regulation was published as 16 DE Reg. 1234 in the June 1, 2013 issue of the Register of Regulations.

DOE regulations include two (2) sets of appraisal standards covering administrators, Part 106 and Part 106A. The latter (Part 106A) version took effect with the 2011-2012 school year. Since the Part 106 standards have been superseded, DOE is repealing them in their entirety. SCPD endorses this "housekeeping" initiative.

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

Sincerely,

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

cc: The Honorable Mark Murphy
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16reg1234 doe-teacher appraisal process repeal 6-24-13



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June 24, 2013

Ms. Susan K. Haberstroh
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RE: 16 DE Reg. 1244 [Proposed Specialist Appraisal Process Repeal Regulation]

Dear Ms. Haberstroh:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) proposal to repeal *14 DE Admin. Code 107 Specialist Appraisal Process Delaware Performance Appraisal System (DPAS II)*. The proposed regulation was published as 16 DE Reg. 1244 in the June 1, 2013 issue of the Register of Regulations.

DOE regulations include two (2) sets of appraisal standards covering administrators, Part 107 and Part 107A. The latter (Part 107A) version took effect with the 2011-2012 school year. Since the Part 107 standards have been superseded, DOE is repealing them in their entirety. SCPD endorses this "housekeeping" initiative.

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

Sincerely,

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

cc: The Honorable Mark Murphy
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Ms. Susan K. Haberstroh
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RE: 16 DE Reg. 1245 [Proposed Specialist Appraisal Process Revision Regulation]

Dear Ms. Haberstroh:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) proposal to revise its specialist appraisal standards effective with the 2013-14 school year. The proposed regulation was published as 16 DE Reg. 1245 in the June 1, 2013 issue of the Register of Regulations. SCPD has the following observations.

A. "Weakening" of Appraisal Process

SCPD and GACEC have previously criticized the DOE's specialist appraisal process as "overly generous" or "misleading". See, e.g., the attached October 21, 2011 SCPD letter which shared the following concerns:

Third, DOE establishes five appraisal components in §5.0: 1) planning and preparation; 2) professional practice and delivery of services; 3) professional collaboration and consultation; 4) professional responsibilities; and 5) student improvement. Unlike the teacher appraisal regulation, these five components are included in the current regulation last revised in May of 2010. Specialists are rated in these five contexts resulting in an overall classification of highly effective, effective, needs improvement, and ineffective. See §6.0. The classification system could be characterized as "overly generous" or "misleading" in some contexts. For example, a specialist scoring a satisfactory rating in only three of the five components inclusive of student improvement (60%) is characterized as "effective". Reasonable persons might view such a characterization as a distortion of the plain meaning of "effective". Likewise, a specialist scoring a satisfactory rating in only one of the five components inclusive of student improvement (20%) is euphemistically characterized as "needs improvement". DOE may wish to revisit the qualifications for "effective" and "needs improvement" to more closely align to the plain meaning of the terms.

Unfortunately, the DOE's proposed regulation further dilutes the already "overly generous" specialist appraisal standards. The following are examples.

1. The current regulation (§5.1) contains four (4) appraisal contexts apart from student achievement: 1) planning and preparation; 2) professional practice and delivery of services; 3) professional collaboration and consultation; and 4) professional responsibilities. There are a total of eighteen (18) subparts under these four (4) appraisal contexts. Under the proposed regulation, districts and charter schools are authorized to "waive" one subpart under each of the four (4) appraisal contexts. No permission is needed, i.e., the district or charter school simply notifies DOE of its decision in August. This results in the option to disregard 22% (4/18) of appraisal components, including the following ostensibly important measures:

5.1.2.3. Communicating Clearly and Accurately: Verbal and written communication is clear and appropriate to students' or clients' ages, backgrounds, needs, or levels of understanding. (Optional)

5.1.1.2. Demonstrating Knowledge of Best Practice and Models of Delivery: Specialist uses practices and models of delivery that are aligned with local and national standards. (Optional)

5.1.4.2. Recording student data in a Record System: Specialist keeps student or client records relevant to their services and shares information with appropriate school personnel. (Optional)

Since each district and charter school can waive different components, valid comparisons of data among districts and charter schools are not possible. Each district and charter school will be using different criteria.

2. DOE proposes to reduce the number of "observations" of novice specialists. Currently, three (3) observations (2 announced; 1 unannounced) are required. See §3.4. This is reduced to two (2) observations (1 announced; 1 unannounced) in the proposed regulation.

3. The DOE proposes to no longer require improvement plans for specialists with an "unsatisfactory" rating during an observation. Such improvement plans will be optional:

8.1.1. An Improvement Plan ~~shall also~~ may be developed if a specialist's overall performance during an observation is unsatisfactory. This unsatisfactory performance ~~shall~~ may be noted by the evaluator ~~on the Formative Feedback form~~ Evaluator on the required forms by noting "PERFORMANCE IS UNSATISFACTORY" and initialing the statement.

B. Unannounced Observations

One proposed change in the standards merits endorsement. The revised standards contemplate more “unannounced” versus “announced” observations of specialists who have earned a rating of “highly effective” or “effective”. See §§3.1 and 3.4. This should result in enhancing the validity and reliability of assessments for such specialists.

C. Miscellaneous

The word “evaluator” in §8.4, second sentence, should be capitalized.

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

Sincerely,



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

cc: The Honorable Jack A. Markell
The Honorable Matthew Denn
The Honorable Mark Murphy
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16reg1245 doe specialist appraisal process revision 6-24-13



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June 24, 2013

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RE: 16 DE Reg. 1235 [Proposed Teacher Appraisal Process Revision Regulation]

Dear Ms. Haberstroh:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) proposal to revise its teacher appraisal standards effective with the 2013-14 school year. The proposed regulation was published as 16 DE Reg. 1235 in the June 1, 2013 issue of the Register of Regulations. SCPD has the following observations.

A. "Weakening" of Appraisal Process

As background, the Legislature and Governor have recently stressed the need to "raise the bar" for the teaching profession in Delaware. See attached May 18, 2013 News Journal article describing enactment of legislation establishing more rigorous standards for prospective public school teachers. Statistically, Delaware student achievement is lagging, resulting in recognition that the status quo approach to promoting the caliber of Delaware's teaching profession must be dramatically changed. See, e.g., the attached 2012 presentation by WSFS Bank Board Chair to Delaware State Chamber of Commerce.

SCPD and GACEC have previously criticized the DOE's teacher appraisal process as "overly generous" or "misleading". See, e.g., the attached October 21, 2011 SCPD letter which shared the following concerns:

Third, DOE has established five appraisal components in §5.0: 1) planning and preparation; 2) classroom environments; 3) instruction; 4) professional responsibilities; and 5) student improvement. The last component, student improvement, is new. Teachers are rated in these five contexts resulting in an overall classification of highly effective, effective, needs improvement, and ineffective. See §6.0. The classification system could be characterized as "overly generous" or "misleading" in some contexts. For example, a teacher scoring a satisfactory rating in only three of the five components inclusive of student improvement

(60%) is characterized as “effective”. Reasonable persons might view such a characterization as a distortion of the plain meaning of “effective”. Likewise, a teacher scoring a satisfactory rating in only one of the five components inclusive of student improvement (20%) is euphemistically characterized as “needs improvement”. DOE may wish to revisit the qualifications for “effective” and “needs improvement” to more closely align to the plain meaning of the terms.

The “overly generous” characterization of an “effective” teacher was recently underscored in the DOE dispute with the Christina School District over teacher bonuses paid with “Race to the Top” funds. Consistent with the attached April 12 and May 17, 2013 News Journal articles, Christina wished to provide the bonuses to all teachers with an “effective rating”, a standard so low that more than 99% of its teachers were expected to qualify.

Unfortunately, the DOE’s proposed regulation further dilutes the already “overly generous” teacher appraisal standards. The following are examples.

1. The current regulation (§5.1) contains four (4) appraisal contexts apart from student achievement: 1) planning and preparation; 2) classroom environment; 3) instruction; and 4) professional responsibilities. There are a total of eighteen (18) subparts under these four (4) appraisal contexts. Under the proposed regulation, districts and charter schools are authorized to “waive” one subpart under each of the four (4) appraisal contexts. No permission is needed, i.e., the district or charter school simply notifies DOE of its decision in August. This results in the option to disregard 22% (4/18) of appraisal components, including the following ostensibly important measures:

5.1.3.3. Communicating Clearly and Accurately: Verbal and written communication is clear and appropriate to students’ ages, backgrounds, and levels of understanding. (Optional)

5.1.1.1. Selecting Instructional Goals: Teacher selects instructional goals that are aligned with the DE content standards and the district or charter school’s curricula. Goals are appropriate for the learners and reflect high expectations for all students, consistent with State Assessment levels of performance where applicable. (Optional)

5.1.1.3. Demonstrating Knowledge of Content and Pedagogy: Teacher shows his or her knowledge of content and how to teach it to a variety of learners. The teacher’s plans include natural connections among content areas that deepen student learning. The content that he or she teaches is aligned to the district or charter school’s curricula. (Optional)

Since each district and charter school can waive different components, valid comparisons of data among districts and charter schools are not possible. Each district and charter school will be using different criteria.

2. The DOE proposes to no longer require improvement plans for teachers with an “unsatisfactory” rating during an observed lesson. Such improvement plans will be optional:

8.1.1. An Improvement Plan ~~shall also~~ may be developed if a teacher's overall performance during an observed lesson is unsatisfactory. This unsatisfactory performance ~~shall~~ may be noted by the ~~evaluator on the Formative Feedback form~~ Evaluator on the required forms by noting "PERFORMANCE IS UNSATISFACTORY" and initialing the statement.

B. Unannounced Observations

One proposed change in the standards merits endorsement. The revised standards contemplate more "unannounced" versus "announced" observations of teachers. See §§3.1, 3.2, and 3.4. This should result in enhancing the validity and reliability of assessments.

C. Miscellaneous

The word "evaluator" in §8.4, second sentence, should be capitalized.

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

Sincerely,



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

cc: The Honorable Jack A. Markell
The Honorable Matthew Denn
The Honorable Mark Murphy
Dr. Teri Quinn Gray
Ms. Mary Ann Mieczkowski
Ms. Paula Fontello, Esq.
Ms. Terry Hickey, Esq.
Ms. Ilona Kirshon, Esq.
House Education Committee
Senate Education Committee
Mr. Brian Hartman, Esq.
Developmental Disabilities Council
Governor's Advisory Council for Exceptional Citizens

16reg1235 doe teacher appraisal process revision 6-24-13

8-5-13
NJ

National science standards considered for Delaware teachers

By Matthew Albright
The News Journal

As Delaware teachers bring their reading and math teaching in line with national standards, Delaware is headed toward adopting a similar program for science courses.

But the standards could again raise debate over teaching evolution and climate change in schools, and some parents are worried they

could be losing control over what their kids are learning.

The Next Generation Science Standards are designed to make science classes more rigorous and to bridge a sometimes wide divide in what is taught in different states, proponents say.

"These are standards that are going to make your child competitive in a global society," said

See STANDARDS, Page A5

Standards: State board planning to vote in Sept.

Continued from Page A1

Tonyea Mead, science associate at the Department of Education.

Among other changes, Mead says the standards aim to engage students in the scientific process.

In the fourth grade, for example, Delaware's current standards require students to know life cycles for a variety of plants and animals. The new standards, Mead said, would require students to analyze the life cycles for their differences.

The State Board of Education is set to discuss the standards at its meeting this month, and will vote next month on whether to adopt them.

The standards include the science of evolution and humans' effects on global climate change.

Delaware's existing standards include evolution, Mead said. She emphasized that both topics are taught "not as an understanding of belief, but an understanding of concepts that are fundamental to our understanding of biology."

Climate change is an important concept for students to know, she said.

"The goal is to give students the facts of what we know, so they can hold a healthy debate based on the evidence," she said.

But teaching climate change has faced opposition in Delaware.

In January, the Sea Level Rise Advisory Committee debated including climate change and sea level rise in public schools. After some members criticized the plan, the committee proposed general public education without specific mention of schoolchildren.

One of those critics was Rich Collins, president of the Positive Growth Alliance.

"What they'll do is, once they indoctrinate our children, which they will, they're going to tell us that we won't be able to go buy gasoline to go on vacation, that we have to build our house in a certain place and that we have to get the blessing of the people who are in control who are better than us," Collins said.

The committee was created by Collin O'Mara, state environmental secretary, to address the effects of sea level rise on Delaware's coasts. Sussex County's representative on that committee announced in May that he had been instructed to abstain from any recommen-

SCIENCE STANDARDS MEETINGS

The meetings will be hosted at 6 p.m. on the following dates and locations:

- » Tuesday, Carvel State Office Building, 9th and French streets, Wilmington
- » Wednesday, Carvel Research and Education Center, 16483 County Seat Highway, Georgetown
- » Thursday, Department of Agriculture, 2320 South DuPont Highway, Dover
- » Aug. 12, DNREC Lewes Field Facility, 901 Pilottown Road
- » Aug. 13, Middletown High School, 120 Silver Lake Road

dation vote — some county officials questioned the science behind climate change.

Some parents are concerned that the standards will leave less control in the hands of local community.

Evan Queitsch is a member of the Delaware Education Reform Coalition, a group of parents, grandparents and teachers who have rallied against a national math and reading standards program.

"This is another national set of standards, as opposed to state or local standards," Queitsch said.

Queitsch also points to groups that have criticized the standards. The Fordham Institute, an Ohio-based education policy think-tank, gave the standards a "C" grade, rating it barely better than Delaware's existing standards.

But Michael Watson, head of teaching and learning at the Department of Education, says the standards are more rigorous. "Scientists and educators, including Nobel laureates, have attested to the high-quality con-

tent and rigor of the Next Generation Science Standards," Watson said.

State officials also emphasize that the standards merely outline what students should know, not telling districts or individual teachers how to go about giving students that knowledge. They also say Delaware has had ample input into the creation of the standards.

Delaware is one of 26 "lead states" that has helped to develop the standards. Some of its teachers and local science leaders, including a scientist from DuPont, were involved in writing them.

Mead said it makes sense for Delaware to be a leader in the standards movement because many families move into or out of Delaware from other states.

The Department of Education is hosting a series of public meetings to discuss the standards. Queitsch said his group is planning to attend some of those meetings to share their concerns.

Matthew Albright can be reached at malbright@delawareonline.com or at 324-2428. Follow him on Twitter @TNI_malbright.

EXCERPTS

Application for a 1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in 1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a 1915(c) Home and Community-Based Services Waiver

1. Request Information

- A. The State of Delaware requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of 1915(c) of the Social Security Act.
- B. Program Title:
Renewal-DDDS Waiver
- C. Waiver Number: DE.0009
Original Base Waiver Number: DE.0009.
- D. Amendment Number:
- E. Proposed Effective Date: (mm/dd/yy)

10/01/13

Approved Effective Date of Waiver being Amended: 07/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Delaware wishes to amend the DDDS waiver to make the following changes:

1. Add Supported Employment - Small Group as a waiver service and related provider qualifications and reimbursement methodology. Providers will bill in 15 minute units
2. Revise the service definition of "Supported Employment" to call it "Supported Employment - Individual" and to clarify that the staff to consumer ratio must be 1:1
3. Add service utilization estimates for Supported Employment - Small Group to Appendix J
4. Change the current billable unit for Day Habilitation, Supported Employment - Individual and Pre-vocational service from hourly to 15 minutes
5. Change the frequency of the Case Manager review of the plan of care from a monthly face to face visit with the consumer and their family or guardian to monthly "paper" reviews of the plan with documentation and four face to face visits per year to review the plan with the consumer/family/guardian and revise the related Quality Improvement performance measure.

3. Nature of the Amendment

- A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following

personal, health, social or financial needs in accordance with program requirements; may coordinate with community resources to obtain client services.
 Experience in making recommendations as part of a clients service plan such as clinical treatment, counseling, or determining eligibility for health or human services/benefits.
 Experience in using automated information system to enter, update, modify, delete, retrieve/inquire and report on data.
 Experience in narrative report writing.

Also with the following knowledge, skills, and abilities:

Knowledge of principles, practices, methods and techniques of social work.
 Knowledge of Federal/State eligibility and assistance requirements including Delaware Hospital for the Chronically Ill admission medicare and medicaid.
 Knowledge of agency, hospital, community functions, resources and eligibility requirements.
 Skill in writing, preparing case histories, summaries, logs, reports and records.
 Skill in interviewing applicants and analyzing, assessing and determining needs.
 Skill in counseling clients and establishing effective working relationships with co-professionals.
 Ability to conduct investigations.
 Ability to work in stressful situations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Division of Developmental Disabilities Services

Frequency of Verification:

Upon hire and annual performance review

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Service Definition (Scope):

Day Habilitation includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished as specified in the participant's service plan. Day Habilitation services can be provided as a full day or hourly. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Day Habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level in completing activities of daily living and instrumental activities of daily living and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings. Day habilitation may not be provided to a participant during the same hours that Supported Employment, Work Services or Community Inclusion is provided.

Transportation to and from the day activity may be provided or arranged by the licensed provider. The licensee shall use the mode of transportation which achieves the least costly, and most appropriate, means of transportation for the individual with priority given to the use of public transportation when applicable and/or appropriate. Transportation expenses are included in the Day Habilitation rate during the initial process of determining an individual rate.

Prevocational Services

Alternate Service Title (if any):

Service Definition (Scope):

Prevocational Services prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services are reflected in the participant's service plan and are directed to habilitative rather than explicit employment objectives. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished or specified in the participant's service plan. Pre-Vocational services can be provided as a full day or hourly. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

These services also focus on enabling the participant to attain or maintain his or her maximum functional abilities in completing activities of daily living as well as instrumental activities of daily living and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, Prevocational Services may serve to reinforce skills or lessons taught in other settings. Prevocational services may not be provided to a participant during the same hours that Supported Employment, Work Services or Community Inclusion is provided. Transportation expenses are included in the Prevocational services rate during the initial process of determining an individual rate.

Prevocational services are not available under a program under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)).

Documentation is maintained in the file of each individual receiving this service that the service is not otherwise available under a program funding under the Rehabilitation Act of 1973, or P.L. 94-142.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
 Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Services

Provider Qualifications

the ELP meetings, when and where it is held. All support team members or their designee are requested to attend the Annual ELP meeting unless otherwise requested by the individual receiving services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Essential Lifestyle Plans are updated, minimally within 365 days of the previous Annual Conference. Plans are updated whenever there is a change in the participant's needs for services and supports.

DDDS attempts to provide information to the person in a way easy to understand so each person is able to make informed choices. DDDS strives to assure during the assessment, plan development, and review/approval processes, the person is assisted by individuals who: know the person well, have demonstrated care and concern for the person, and are trusted by the person.

With this approach, each participant is assisted in selecting a facilitator for his/her ELP development. The facilitator is an individual who has successfully completed the ELP Facilitator Training offered by the DDDS, and who is responsible for putting information learned about a person receiving services into the person's ELP document. Typically this person is the DDDS State Case Manager or a person selected by the individual (See qualifications in section D-1-a.).

The facilitator begins preparing for the ELP development with information the person communicated important to him/her. That information includes the things the person must have, the person's likes & dislikes, their positive attributes, and significant events or accomplishments of the past year.

Included in the ELP development is information identifying how services and supports will enhance the person's life. This information is obtained from a variety of assessment sources including: the Physical Exam Data from the Person's Primary Care Physician, the Comprehensive Medical Evaluation, the IPOP's, and the IOSA.

This assessment data, including information about services the participant receives through other state and federal programs is coordinated by the DDDS case manager. The case manager's coordination efforts help to assist the participant with plan development, and to ensure the ELP accurately reflects such services or programs.

All support team members or their designee are invited to attend the Annual ELP meeting unless otherwise requested by the individual receiving services. Issues the person does not wish to discuss at the Annual ELP Meeting, are discussed with appropriate team members and outlined in the final draft of the ELP.

All members of the support team have input and review the Essential Lifestyle Plan prior to implementation. During the meeting, the support team with the input of the person identify and assign responsibilities for implementing (the agency) and monitoring (the state) the plan. Each responsible person is identified in writing, the frequency of monitoring is identified, and the reporting/accountability requirements is identified in the ELP.

Approval of the Essential Lifestyle Plan:

At the end of the ELP document is a section with lines for the signatures of either the agency program coordinator or the DDDS Case Manager who reviewed the plan for technical detail, as well as for inclusion of all participant identified services and supports. Signature space is available for; the participant, the participant's family or guardian, an advocate, the contracted provider, the state Case Manager, the Case Manager Supervisor or the DDDS Regional Program Director, and an advocate as selected by the participant. This inclusive list of signatures constitutes the DDDS system for plan approval.

- Review the participant's progress toward goals stated in the ELP.
- Assess and review the funds of the participant to ensure they are properly managed for the participant's benefit and to maintain waiver eligibility.

During the face to face monitoring of the plan that occurs four times each year, the Case Manager will:

- Remind participants that they have free choice of qualified providers.
- Remind participants, providers, and informal caregivers that they should contact DDDS if they believe services are not being delivered as agreed upon at the most recent ELP meeting.
- Observe whether the participant feels healthy and not in pain or injured.
- Interview the participant and others involved in the participant's services to identify any concerns regarding the participant's health and welfare.

If at any point there is belief that a participant's health and welfare is in jeopardy, actions must be taken immediately to assure the person's safety. In a less serious issue, the team will work with the participant, service providers and/or informal supports to address the issue. Depending on the severity and scope of the issue, the State DDDS Case Manager/Agency Program Coordinator may reconvene the planning team to address the issue.

Required Contracted Provider reports of service monitoring are as follows:

- Monthly ELP Progress Report-** Completed by the person's Contracted Provider Agency. The Contracted Provider Agency Monthly ELP Progress report looks at identified priority outcome on the ELP Action Plan, and reports on the status of implementation. What is the status of developing the supports for the individual to attain his/her desired outcomes? Is there a concern or problem supporting the person? The Contracted Provider Agency comments as to what actions or steps are taken to support the person's attainment of identified outcomes.
- Monthly Nursing Audit-** Completed by the person's identified Registered Nurse. This tool is used to track and monitor all health related services the person receives, as identified on the ELP. The nurse completes the report and provides findings to the provider agency so any corrections or issues needing follow-up may be addressed by the provider agency. Generally, the residential manager and/or the Support Coordinator receive this review through either a Therap report or a hard copy report in the person's record.
- Quarterly Day Service/Vocational/Work Reports-** The providers of such services report on the person's progress as related to identified priority outcomes and goals on a quarterly basis. The reports are entered on the Therap system or hard copies are forwarded to the Support Coordinator for inclusion in the person's record.
- Quarterly Behavioral Reports-** For persons who have identified behavioral support needs with active plans to address the issues, the Behavior Analyst or Psychological Assistant provide a quarterly data based report on the person's progress. Frequency of reporting may occur at more frequent intervals for person with intensive behavioral support needs.
- Other progress reports are provided as identified and defined in the person's ELP.

Such reports are based upon the person's support needs and identified priority outcomes.

- All reports are designed to assess the quality of the services and supports the individual receives and to stimulate quality improvement activities with each person's priority outcomes as identified on the ELP.
- Each person/discipline providing the service, support, and monitoring activity is required create annual assessment and progress reports and is used by the person and his/her selected support network for subsequent plan development/update activities.
- DDDS and all authorized service providers use T-Logs within the Therap web-based electronic system to document notes regarding contacts with participants, providers, family members and informal supports. All team members must document their communication and actions regarding the waiver participant in Therap.

Office of Quality Management Oversight:

The DDDS Office of Quality Management (OQM) completes Certification of Services reviews for a random sample of participants at the 95% Confidence Level. In addition, the OQM identifies Service Providers and licensed entities that were not captured by the sample selection. For those entities, the OQM completes full certification reviews above and beyond the random sample in order to make evidence based recommendations for contract renewal of all active service providers.

On an annual basis OQM also completes an interview of the providers- the Provider Questionnaire. The results of these three tools are provided to DMMA on an annual basis for the agency to review waiver operations with DDDS.

OQM uses a variety of other review tools in order to assess compliance with applicable standards and regulations. Identified deficiencies in services are identified in order to stimulate agency provided Improvement Plans. In addition the DMMA tools that are reviewed for quarterly trend analysis, the results of the regulation based certification reports are analyzed for identification of systems deficiencies and the development of systemic improvements.

These OQM reports assess Agreements to Participate, Levels of Care, Choice in Selecting Services, and adequacy of services provided. Negative findings from these reports are used to identify deficient practices and to stimulate agency provided improvement plans.

b. Monitoring Safeguards. Select one:

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The case manager is responsible for service plan development for waiver participants.

In order to ensure the Essential Lifestyle Plan (service plan) monitoring conducted by those furnishing direct services is in the best interest of the waiver participant, the DDDS utilizes a variety of service review processes and sources. As indicated in section D-a-1, the State DDDS Case Manager/Agency Program Coordinator is responsible for the implementation of, and reporting on the status of the services and supports the participant has identified- this includes both waived and non-waived services.

The DDDS Case Manager reviews and monitors the implementation of services at least monthly through a direct, person to person meeting and discussion with the participant. The Case Manager reports findings from review activities to the agency for implementation of Improvement Plans or actions to resolve the participant's concerns.

The DDDS Case Manager's role reflects a position of advocacy for the participant to receive satisfaction with his/her desired and identified outcomes. As there are situations in which the DDDS Case Manager may perform supports or services for the participant- such as to serve as the selected ELP Facilitator- DDDS oversight of services includes additional monitoring safeguards.

Primary system wide monitoring is implemented by the DDDS Office of Quality Management (OQM). The DDDS table of organization was structured for the OQM to report directly to the Division Director, as opposed to the Director of Community Services. Therefore, the OQM is accountable to the Division Director to provide accurate and objective data based performance reviews of waived services and programs.

Administratively, the positioning of the OQM under the Division Director protects the OQM from an alleged conflict of interest in reporting survey results. Were the OQM accountable to report directly to any of the DDDS operational units charged with the responsibility for direct waiver monitoring, then it could pose a concern that hard issues would be avoided and/or glossed over.

The OQM has full access to review all pertinent information related to participant in order to review and assess all services and supports provided for the waiver participants. Level of Care Assessments, Incident Reports (General Event Reports on Therap), Individual Plans of Protective Oversight and Safeguards (IPOPS), Nursing Reports and Essential Lifestyle Plans- including medical/psychiatric and behavioral portions, are examples of reports OQM has access to.

	Ongoing	Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

D-c-2: The percentage of Plans of Care indicating services and supports were revised when an individual's needs changed. (The number of Plans of Care indicating services and supports were revised when an individual's needs changed/number of plans reviewed).

Data Source (Select one):

Other

If 'Other' is selected, specify:

The Division s Office of Quality Management's Individual Focused Certification Review Data Base.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

salary expense for the direct care workers providing each type of service. Mercer also reviewed wage data provided by the Bureau of Labor Statistics.

In developing the other three rate components, Mercer first determined the allowable costs to be funded through each service and included only allowable indirect and administrative expenses.

Mercer used this information to develop rates that comply with the requirements of Section 1902(a)(30)(A) of the Social Security Act (... "payments are consistent with economy, efficiency, and quality of care and are sufficient to enlist enough providers") and the related federal regulations at 42 CFR 447.200-205. The State of Delaware reviews the rate setting model every three years to ensure the adequate access to services and appropriate levels of reimbursement are maintained.

The component parts of the rates are cross walked or translated into a total number of support hours needed by each person as determined through the completion of the Inventory for Client and Agency Planning (ICAP) assessment tool. The ICAP assessments are performed face-to-face by an independent clinician for whom the state contracts (Arbitre Consulting, Inc.). The contractor submits the completed assessments via a HIPAA compliant means to the State. The ICAP assessment scores are used to generate a daily rate for the individual receiving services. For individuals receiving "prevocational - daily" or "day habilitation - daily" services, the daily rate is calculated through the use of a matrix which specifies the needed hours of service based on ICAP generated Broad Independence and General Maladaptive scores. These hours of services are converted to a daily rate by multiplying the needed hours of services by a rate per hour. The hourly rate is calculated using a set direct care wage and includes percentage add-ons for Employee Related Expenses (ERE), Program Indirect (PI) Expenses and Contract Administration. For individuals receiving "prevocational - hourly" or "day habilitation - hourly" services, the hourly rate, defined above, is paid for the actual hours of service received, billed in 15 minute increments.

Rates for day programs and prevocational services also have add-ons for Transportation and Facility costs. Rates are calculated by the DDDS Office of Budget, Contracts and Business Services. The rate setting system/methodology is outlined in the Mercer final report and the ICAP Rate Setting Matrix located on the State of Delaware website under Delaware Health and Social Services, Division of Developmental Disabilities Services, Individual Rate Setting.

Provider agencies and/or participants have the right to request a review of a rate if they do not feel the calculated rate is adequate. In a review, the agency/participant submits supporting documentation to the Director of Community Services who makes a recommendation for an exception to the Chief of Administration. The base unit rates, ERE and PI percentages, transportation and facility add-ons and matrix are published and are available for public comment and input. The ICAP rate process and establishment of rates are approved by the Delaware Division of Medicaid and Medical Assistance (DMMA) and the Rate Setting Committee.

Rates for "Supported Employment - Individual" have been calculated using actual cost data as reported by providers of Supported Employment Services. Total Medicaid allowable costs for each provider were tabulated and divided by total direct care staff (job coaches, employment specialists) hours worked. This provided a cost per hour for each provider based on direct care staff hours. The average cost per hour across all agencies was used to compute an hourly rate, which is expressed as a 15 minute billable unit by dividing the hourly rate by four.

Rates for Supported Employment - Small Group are based on the rate for Supported Employment - Individual, which is a one-to-one staff-to-consumer ratio. The payment rate for the addition of each consumer in the group shall be computed by dividing the payment rate for Supported Employment - Individual by the number of participants in the group (up to a maximum of 8) and applying a gross up factor to account for additional incremental costs related to the provision of group supported employment that would not have been captured in the base rate for Supported Employment - Individual. Supported Employment - Small Group will be paid in 15 minute billable units.

The rates for the services of the State of Delaware operated Day Programs are calculated based on the total actual annual costs, including personnel, benefits, supplies, and administration or overhead. The total actual costs are used to calculate a daily rate for this service. The Day Program rate is approved by Delaware's DMMA and Revenue Management Units. This area has been incorporated into an approved work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan. The work plan includes the revision of the rate methodology for State Run Day Habilitation, Residential Habilitation, DDDS State Case Management, and Clinical/Behavioral consultative services. Transportation costs are now included in, and have been built into, the Residential Habilitation Services rate. See Work plan Section II.A.1-II.A.11 & III.A.1- III.A.7

Behavioral Consultation Services □ a single statewide rate will be developed for this service as follows. The midpoint of the salary range for the State of Delaware merit classification of Senior Behavior Analyst will be used as the basis of the computation of an hourly wage. A fringe benefit factor is added to the hourly wage based on the

Delaware State Employee fringe benefit package. A factor of 12% is added to the computed hourly wage that includes other employment costs to account for other direct non-salary costs such as training, supervision and travel. A separate factor of 12% is added on top of the computed hourly wage to account for administrative costs necessary to support the direct service. A 15 minute billable unit is computed by dividing the resulting hourly wage by four. The provision of behavioral consultation services and related documentation of the provision of service shall be billable in 15 minute increments. Units of time 1- 8 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

Nursing Consultation Services □ a single statewide rate will be developed for this service as follows. National average hourly wage data is obtained from the Bureau of Labor Statistics, Occupational Employment Statistics survey of the US DOL for the Registered Nurse job classification SOC code 29-1111 (Registered Nurse) in the industry code NAICS 623210 Residential MR Facilities. A fringe benefit factor is added to the hourly wage based on the Delaware State Employee fringe benefit package. A factor of 12% is added to the computed hourly wage that includes other employment costs to account for other direct non-salary costs such as training, supervision and travel. A separate factor of 12% is added on top of the computed hourly wage to account for administrative costs necessary to support the direct service. A 15 minute billable unit is computed by dividing the resulting hourly wage by four. The provision of nursing consultation services and related documentation of the provision of service shall be billable in 15 minute increments. Units of time 1- 8 minutes shall not be billed. Units of time 8-15 minutes shall be billed as one 15 minute unit.

- b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

As with billings for all services provided under the Delaware Medical Assistance Program (DMAP), claims for HCBS waiver services are adjudicated by the State's Medicaid Fiscal Agent, HP, in the MMIS which it manages for DMMA. Providers submit electronic claims in the HIPAA standard 837 transactions (professional or institutional) first to a clearinghouse, Business Exchange Services (BES) which screens them against both HIPAA and Delaware proprietary minimum claim criteria. Claims are accepted, in which case they pass to the MMIS for adjudication if they meet the minimum criteria, or are rejected back to the provider along with the rejection reason. Providers can submit paper claims on the HCFA 1500 or the UB04 directly to HP. Paper claims are scanned into the MMIS. Providers can use any claims software resulting in a HIPAA standard clean claim. HIPAA compliant claims software is made available to DMAP providers free of charge via download from the DMAP website. Provider billing procedures are described in detail in a series of Provider Manuals on the DMAP website.

Provider claims are accepted 24/7 and are processed for payment once a week after the close of business each Friday. Funds for paid claims are available for payment the Monday following the Friday financial cycle. Providers may elect to receive payments via paper check or EFT.

This area has been incorporated into an approved work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan. See Work plan Section II.A.1-II.A.11 & III.A.1- III.A.7

The billing for state-operated day habilitation, residential habilitation, residential transportation, case management services, and state clinical consultative services are entered as the State of Delaware/DDDS being the provider agency (where/when applicable). This area has been incorporated into an approved work plan and will be revised in accordance with the goals, objectives and timeframes identified in the work plan. See Work plan Section II.A.1-II.A.11 & III.A.1- III.A.7

The State of Delaware submits electronic claims in the HIPAA standard 837 transactions (professional) first to a clearinghouse, Business Exchange Services (BES) which screens them against both HIPAA and Delaware proprietary minimum claim criteria. Accepted claims are passed to the MMIS for adjudication if they meet the minimum criteria, or are rejected back to the State along with the rejection reason. The State of Delaware uses HIPAA compliant claims software that is made available to DMAP providers free of charge via download from the DMAP website.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. **Certifying Public Expenditures** (*select one*):

The payment for case management is a workplan item and the waiver will be modified to reflect the change to an administrative function. Transportation payment is a workplan item as well. Clinical Support payment issues will be addressed as a workplan action steps.

(b) The participants' Essential Lifestyle Plan lists and details the approved services prepared at the beginning of services and re-evaluated at a minimum annually or on an as needed basis (when applicable as situations change) thereafter. Once eligible for HCBS waiver services a contract is secured for the individual receiving services and their chosen provider(s). HCBS waiver services are pre-authorized by the state contract manager and entered into in the Atlantes Care Management System based on services selected by each participant during the ELP process. The MMIS checks each claim submitted by a provider against the eligibility record to insure the person receiving service was eligible for waiver services on the date of service and the service was authorized and did not exceed programmed service limitations as set by the pre-authorization.

Per the MOU between DMMA and DDDS, DDDS periodically reviews claims data against plans of care to monitor over and under utilization of services. DMMA is responsible for retrospective auditing of paid claims and utilization review of services provided through DDDS.

(c) Before a claim is processed there must be verification the service was provided. This verification varies according to the service; however the verification must be in writing and signed (either written or electronically) by the provider of service. The agencies providing residential, day, prevocational, and supported employment services are required to submit attendance/utilization reports to the DDDS monthly. These attendance reports are signed by a provider employee and verified by a provider supervisory employee as to verify that services were rendered.

Also, during the claims adjudication process, the MMIS is programmed to select a random sample of participants for whom claims were submitted (which will include DDDS Residential waiver participants) the system generates a letter on pre-printed state letterhead to be mailed to each of the selected participants. The letter provides the participant with dates, provider names and specific procedures which Medicaid has been asked to pay on behalf of that participant and asks the participant to indicate whether or not the services were provided and whether he/she was asked to make any payment for these services. It also provides a space for any comments the participant wishes to make. The participant is directed to mail the letter back. Returned letters warranting further investigation are referred to the Surveillance and Utilization Review (SUR) Unit (See Appendix I-1).

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Case Management Total:						4275571.20
Case Management	Month	940	12.00	379.04	4275571.20	
Day Habilitation Total:						7092600.00
Day Habilitation - Daily	Day	240	250.00	118.21	7092600.00	
Day Habilitation - 15 minutes	Hour	0	0.00	0.01	0.00	
Prevocational Services Total:						9064800.00
Prevocational Services - Daily	Day	480	250.00	75.54	9064800.00	
Prevocational Services - 15 minutes	Hour	0	0.00	0.01	0.00	
Residential Habilitation Total:						66428209.50
Residential Services	Day	745	360.00	238.25	63898650.00	
Shared Living Arrangement	Day	195	365.00	35.54	2529559.50	
Supported Employment - Individual Total:						1693612.50
Supported Employment - Daily	Day	95	250.00	71.31	1693612.50	
Supported Employment - 15 minutes	Hour	0	0.00	0.01	0.00	
Supported Employment - Small Group Total:						0.00
Supported Employment - Small Group		0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services Total:						4984608.00
Behavioral Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Nursing Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services	Month	685	12.00	606.40	4984608.00	
Transportation - Residential Services Total:						1226476.80
Transportation - Residential Services	Month	535	12.00	191.04	1226476.80	
GRAND TOTAL:						94765878.00
Total Estimated Unduplicated Participants:						940
Factor D (Divide total by number of participants):						100815.00
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to

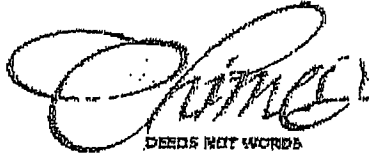
automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Case Management Total:						4546651.20
Case Management	Month	980	12.00	386.62	4546651.20	
Day Habilitation Total:						7536250.00
Day Habilitation - Daily	Day	250	250.00	120.58	7536250.00	
Day Habilitation - 15 minutes	Hour	0	0.00	0.01	0.00	
Prevocational Services Total:						9920187.50
Prevocational Services - Daily	Day	515	250.00	77.05	9920187.50	
Prevocational Services - 15 minutes	Hour	0	0.00	0.01	0.00	
Residential Habilitation Total:						70514986.25
Residential Services	Day	775	360.00	243.02	67802580.00	
Shared Living Arrangement	Day	205	365.00	36.25	2712406.25	
Supported Employment - Individual Total:						1818500.00
Supported Employment - Daily	Day	100	250.00	72.74	1818500.00	
Supported Employment - 15 minutes	Hour	0	0.00	0.01	0.00	
Supported Employment - Small Group Total:						0.00
Supported Employment - Small Group		0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services Total:						5344099.20
Behavioral Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Nursing Consultative Services	Quarter Hour	0	0.00	0.01	0.00	
Clinical Consultative Services: Behavioral Consultative Services/Nursing Consultative Services	Month	720	12.00	618.53	5344099.20	
Transportation - Residential Services Total:						1314135.84
Transportation - Residential Services	Month	562	12.00	194.86	1314135.84	
GRAND TOTAL:						100994809.99
Total Estimated Unduplicated Participants:						980
Factor D (Divide total by number of participants):						103055.93
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)



Vocational Monthly Note

Between: 6/1/13 and 6/30/13

SAMPLE

Newark Delaware

Employee #: Employee Name:
Case Manager:

Dear

has worked on the following contracts between 6/1/13 and 6/30/13
If you have any questions or concerns regarding the below information, please feel free to contact me
at any time at 1-800-9CHIMES.

CODE	DESCRIPTION	HOUR	UNITS	GROSS SE PAY
AA0001001	A & A Co Parkway Machine co Contract Production			\$0.00
MH0001001	Material Handling/ Warehouse inside Warehouse - moving product			\$0.00
NON006001	Facility Closed Non Production			\$0.00
NON026001	Absent Non Production			\$0.00
NON023001	Arrived Late or left early Non Production			\$0.00



Vocational Monthly Note

Between: 6/1/13 and 6/30/13

Newark Delaware

Employee #: Employee Name:
Case Manager:

Work Hours

	Hours	Percentage	units
Community Employment	0	0.00%	NA
Supported Employment	0	0.00%	NA
Assessments	0	0.00%	NA
Contract hours		100.00%	1.500
Total work Hours			

Wage

	Pay	Percentage
Work center Pay		100.00%
Supported Employment	\$0.00	0.00%
Total Pay		
Avg. Wage		

Behavioral

	Hours	Percentage
Refusal	0	0.00%
Behavioral Interference	0	0.00%
Behavioral interference from others	0	0.00%
Total Behavior Hours Interfering W/pay	0	

Non Work Activities

	Hours	Percentage
Transportation		0.00%
Intergration		0.00%
Absent		48.70%
Late/Early arrival		39.13%
Closed		12.17%
Refusal		0.00%
Breaks/ Trasiitions		0.00%
Other Non-Work Hrs		0.00%
Total Non-Work Hrs		0

Percentage of Intergration Activities

Community Emp. Hrs	Supported Emp. Hrs	Asses ments	Transportation	Other Hours
0	0		0	0
Total Chimes Hrs	Absent Hr	Late/ Early	Closed	Adjusted Chime Hrs

Total Integration hrs	0
Total Integration hrs	0.00%



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
MARGARET M. O'NEILL BUILDING
410 FEDERAL STREET, SUITE 1
DOVER, DE 19901

VOICE: (302) 739-3620
TTY/TDD: (302) 739-3699
FAX: (302) 739-6704

MEMORANDUM

DATE: June 24, 2013

TO: Ms. Elizabeth Timm, DFS
Office of Child Care Licensing

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

RE: 16 DE Reg. 1257 [DFS Proposed Residential Child Care Facility & Day Treatment Programs Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Services for Children, Youth and Their Families/Division of Family Services (DFS)/Office of Child Care Licensing's proposal to amend the Delaware Requirements for Residential Child Care Facilities and Day Treatment Programs. The proposed regulation was published as 16 DE.Reg. 1257 in the June 1, 2013 issue of the Register of Regulations.

As background, the Governor issued Executive Order 36 on January 4, 2012 establishing a schedule for agencies to solicit input from the public on regulations in effect for more than three years. DFS notes that it received few comments on its "Delacare" standards covering residential child care facilities and day treatment programs. Consistent with the Summary, it intends to initiate a comprehensive review of its standards in the Fall of 2013. SCPD has the following technical observations on the proposed regulation.

First, the Division is substituting "regulation" for "requirement" throughout the standards. The substitutions are generally acceptable. However, in a few contexts, the substitution results in "odd" or incomplete references. See, e.g., reference to "Regulations of 1.0, 2.0, 3.0 and 4.0" (§5.1.1 and §7.1.1); and reference to "Regulations of 1.0, 2.0, and 3.0" (§8.1.1). We suspect the Division intended to refer to "Regulations of Chapters 1.0, 2.0, ...". Compare §9.1.1, §10.1.1, and §11.1.1.

Second, the Division may wish to reconsider the substitution of "regulations" for "requirements" in §10.4.2.

Third, §11.11 requires all toys to be confirmed to be “of safe construction, non-toxic, and free of hazards” and checked with a “choker tube” to ensure parts cannot be swallowed by a child under age 3. Section 11.11.2.8 disallows the presence of any toy in a crib or playpen when an infant is asleep. There is no definition of “infant” but the OCCL licensing regulations for day care centers (Part 101) define an infant as a child under age one. Our concern is that some infants may be very “attached” to a particular toy as a “comfort” item and may not be predisposed to sleep without it. If all toys are checked for hazards, query whether the presence of a single toy in a crib or playpen is a realistic danger. DFS may wish to reconsider the total ban on any toy in a crib or playpen when an infant is asleep.

Fourth, given the anticipated thorough review of the standards in the Fall and “involvement of a wide cross-section of stakeholders”, SCPD would like to offer technical assistance to the process.

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

cc: Ms. Vicky Kelly
Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

16reg1257 dscyf-dfs-residential.child care facility 6-24-13

TITLE 24

Professions and Occupations

CHAPTER 37. SPEECH/LANGUAGE PATHOLOGISTS, AUDIOLOGISTS, AND HEARING AID DISPENSERS

Subchapter IV. Speech/Language Pathology Assistants

§ 3721. Definitions.

The following words, terms and phrases, when used in this subchapter, shall have the meanings ascribed to them under this section, except where the context clearly indicates a different meaning:

(1) "Speech/language pathology assistant" shall mean an individual who is licensed to practice as a speech/language pathology assistant pursuant to this subchapter and who meets the Board's qualifications, which permit such speech/language pathology assistant to assist the supervising speech/language pathologist in the implementation of treatment and other defined activities under the direct or indirect supervision of the speech/language pathologist, as set forth in the Board's rules and regulations.

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(2) "Supervising speech/language pathologist" shall mean the individual who holds an active, permanent Delaware license who supervises the speech/language pathology assistant and who shall be responsible for complying with the Board's supervision requirements, as set forth in the Board's rules and regulations.

§ 3722. License required.

(a) No individual shall engage in practice as a speech/language pathology assistant or hold himself or herself out to the public in this State as being qualified to practice the same; or use in connection with that person's name, or otherwise assume or use, any title or description conveying or tending to convey the impression that the individual is qualified to practice as a speech/language pathology assistant, unless such individual has been duly licensed under this subchapter.

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(b) Whenever a license to practice as a speech/language pathology assistant in this State has expired or been suspended or revoked, it shall be unlawful for the individual to practice as a speech/language pathology assistant in this State.

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§3723. Qualifications of applicant; report to Attorney General; judicial review.

(a) An applicant who is applying for licensure under this subchapter shall submit evidence, verified by oath and satisfactory to the Board, that such individual:

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(1) Has received a bachelor's degree or higher from a speech/language pathology program at an accredited institution;

Deleted: an associate's degree or higher from a speech/language pathology assistant program at an accredited institution; or has received an associate's degree or higher in an allied health field from an accredited institution, with credit hours as set forth in the Board's rules and regulations. The authority to approve the curriculum or the equivalent courses for speech/language pathology assistants is vested in the Board

(2) Has completed, prior to making application for a temporary license, the required supervised clinical practice experience, as set forth in the Board's rules and regulations;

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(3) Has obtained a temporary license as a speech/language pathology assistant, as set forth in the Board's rules and regulations;

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(4) Has completed a thirty-six week period of temporary licensure under the supervision of a licensed speech/language pathologist, as set forth in the Board's rules and regulations; and

(5) Has submitted a licensure application, including a Proficiency Checklist, completed by the supervising speech/language pathologist(s), with the required application fee. The Proficiency Checklist shall meet the criteria as set forth in the Board's rules and regulations.

(b) All applicants shall meet the requirements set forth in Sections 3708(b)(1)-(3), 3708(c)-(d).

§ 3724. Temporary license.

The Board may issue a temporary license to practice as a speech/language pathology assistant to an applicant who completes the application, pays the temporary license fee and who has completed all academic and clinical requirements as set forth in §§3723(a)(1) and (2) and who meets the requirements of §3723(b). The application shall be accompanied by a copy of the Supervisory Plan signed by the supervising speech/language pathologist. The Board may grant an extension of the temporary license as set forth in the rules and regulations.

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§3725 Supervision.

(a) The speech/language pathology assistant shall not practice independently but only under the supervision of a licensed speech/language pathologist as set forth in the Board's rules and regulations.

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(b) The speech/language pathology assistant shall not represent himself or herself as a licensed speech/language pathologist.

(c) The Board shall determine in its rules and regulations the number of speech/language pathology assistants and/or clinical fellows that a supervising speech/language pathologist may supervise and the requirements of supervision.

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6.0 Requirements for Speech/Language Pathology Assistants

6.1 Definitions

6.1.1 “Direct supervision” means on-site, in view observation and guidance by the supervising speech/language pathologist while the speech/language pathology assistant is providing services.

6.1.2 “Indirect supervision” means that the supervising speech/language pathologist is either physically present or readily available by telephone or electronic device while the speech/language pathology assistant is providing services.

6.2 Education

6.2.1 An applicant shall have received a bachelor’s degree or higher from a speech/language pathology program at an accredited institution.

6.2.2 The course work shall include 25 clock hours of direct, onsite observation of an ASHA certified speech/language pathologist.

6.3 Clinical practice experience

6.3.1 The applicant shall have completed a minimum of 125 clock hours of clinical practice experience. The experience shall have been obtained by one of the following methods:

6.3.1.1 Clinical practice experience may be obtained through a speech/language pathology program at an accredited institution. The experience shall consist of completion of a minimum of 125 clinical practice hours with 100% direct supervision provided by an ASHA certified speech/language

6.3.1.2 In the alternative, clinical practice experience may be obtained outside of the setting of an accredited institution, through 100% direct supervision by an ASHA certified speech/language pathologist(s) with at least five years of post-certification experience. The clinical practice experience shall consist of completion of a minimum of 125 clinical practice hours. A plan for clinical experience shall be prepared in collaboration with the speech/language pathology assistant student and signed by both the supervising speech/language pathologist and the speech/language pathology assistant student. Each supervising speech/language pathologist shall complete an assessment of proficiency for the applicant, on a Board-approved form, to verify achievement of clinical skills and completion of the required clinical hours. A supervising speech/language pathologist who is providing 100% direct supervision shall not supervise more than one speech/language pathology assistant student at any given time.

6.4 Application process – Temporary Licensure

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Deleted: assistant program at an accredited institution, or an associate’s degree or higher in an allied health field from an accredited institution.¶
Deleted: 6.2.2 An applicant shall have completed at least the following course work: ¶
6.2.2.1 General education, shall consist of a minimum of 20 college level semester credit hours, including at least three credit hours in each of the following areas:¶
Oral and written communication . . . ¶
Mathematics ¶
Computer applications ¶
Social and natural sciences¶
6.2.2.2 Technical education shall consist of a minimum of 20 college level semester credit hours, including at least three credit hours in each of the following areas:¶
Overview of normal speech-language development¶
Overview of communication disorders¶
Cultural and linguistic factors in communication¶ ... [1]
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Deleted: where the applicant did not attend a speech/language patholog... [2]
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6.4.1 An applicant shall have completed a notarized application for licensure. Items which must be provided to the Division of Professional Regulation include:

6.4.1.1 Official transcript(s) showing completion of education requirements, as set forth in Rule 6.2;

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6.4.1.2 Documentation on a Board approved form that the applicant has successfully completed the required clinical practice experience hours, as set forth in Rule 6.3;

6.4.1.3 Supervisory plan, on a Board-approved form, completed by the supervising speech/language pathologist and the speech/language pathology assistant applicant; and

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6.4.1.4 Payment of appropriate fees.

6.4.2 A temporary license is valid for one year from the date of issuance and may be renewed for one additional one year period in extenuating circumstances upon application to the Board. Requests for Board consideration of a renewal shall be made in writing and sent to the Division of Professional Regulation 60 days prior to expiration.

~~6.4.3 During the one year period of temporary licensure, the speech/language pathology assistant shall successfully complete a 36 week period of clinical experience.~~

~~6.4.4 During the one year period of temporary licensure, the supervising speech/language pathologist shall provide direct supervision of patient/client care for no less than 30% of the patient/client contact on a weekly basis. The balance of the clinical experience shall be under indirect supervision.~~

~~6.4.5 During each week, data on every patient/client seen by the speech/language pathology assistant shall be reviewed by the supervising speech/language pathologist.~~

~~6.4.6 The direct supervision shall be scheduled so that all patients/clients seen by the speech/language pathology assistant are directly supervised on a timely basis.~~

~~6.4.7 Supervision days and times of day shall be alternated to ensure that all patients/clients receive direct contact with the supervising speech/language pathologist at least once every two weeks.~~

6.5 Application process – Permanent licensure

6.5.1 An applicant shall have completed a notarized application for licensure. Items which must be provided to the Division of Professional Regulation include:

6.5.1.1 Documentation of successful completion of the thirty-six week period of temporary licensure. Such documentation shall include a Board-approved Proficiency

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Checklist form. The Proficiency Checklist form shall be completed by the supervising speech/language pathologist every twelve weeks. The applicant shall have achieved a “competent” rating in at least 80% of the categories listed on the final Proficiency Checklist form, which shall be submitted with the application.

6.5.1.2 Payment of appropriate fees.

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6.6 Functions and duties of speech/language pathology assistant

6.6.1 A speech/language pathology assistant shall wear a badge that includes the job title: “Speech/language pathology assistant.” The individual must identify himself or herself as a speech/language pathology assistant in all situations.

Deleted: 6.6 Supervision requirements for thirty-six week period of temporary licensure: Every 12 weeks, the speech/language pathology assistant practicing under a temporary license shall receive direct supervision from the supervising speech/language pathologist for a minimum of 20 hours, with the balance of hours worked under indirect supervision.

6.6.2 A speech/language pathology assistant shall comply with the Code of Ethics set forth in Board Rule 9.0.

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6.6.3 A speech/language pathology assistant may engage only in duties that are planned, designed and supervised by a licensed speech/language pathologist. Appropriate duties may include the following:

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The provision of patient/client treatment, or assistance with patient/client treatment, following the individualized treatment plan prepared by the supervising speech/language pathologist and with access to supervision.

The assistance with the screening of speech, language or hearing, without clinical interpretation of results.

The recording, charting, graphing or otherwise displaying of data which reflects the performance of the individual receiving services pursuant to the protocols and treatment plan developed by the supervising speech/language pathologist.

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The maintaining of clinical records.

The reporting of changes in the performance of the individual receiving services to the supervising speech/language pathologist.

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The preparing of clinical materials.

The participating with the supervising speech/language pathologist in research projects, in-service training, public relations programs and similar activities.

6.6.4 A speech/language pathology assistant shall not engage in any of the following activities:

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6.6.4.1 The provision of patient/client treatment, or assistance with patient/client treatment, without following the individualized treatment plan prepared by the supervising speech/language pathologist and without access to supervision.

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6.6.4.2 The screening, assessment, diagnosis or treatment or education of patients/clients for feeding/swallowing disorders.

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6.6.4.3 The formulating of diagnostic statements, clinical management strategies or treatment procedures.

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6.6.4.4 The determining of eligibility for services or discharge.

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6.6.4.5 The making of recommendations for additional services.

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6.6.4.6 The transmitting of clinical information, including data or impressions bearing on the performance, behavior or progress of an individual served, either verbally or in writing, to anyone other than the supervising speech/language pathologist.

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6.6.4.7 The participating in parent conferences, case conferences, or any interdisciplinary team meeting without the presence of the supervising speech/language pathologist or other speech/language pathologist designated by the supervising speech/language pathologist.

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6.6.4.8 The writing, development or modification of a patient or client's individualized treatment plan or the signing of formal documents, such as treatment plans, reimbursement forms or reports.

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6.6.4.9 The composing of clinical reports.

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6.6.4.10 The using of a title, either verbally or in writing, other than speech/language pathology assistant.

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6.6.4.11 Activities which require the formal education or training, and the skill and knowledge, of a speech/language pathologist.

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6.7 Responsibility of the speech/language pathologist

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6.7.1 A speech/language pathologist who supervises a speech/language pathology assistant shall be responsible for:

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6.7.1.1 Supervising only speech/language pathology assistants who meet the minimum requirements under 24 Del. C. §3723 and Board Rules 6.2 and 6.3 (relating to minimum education and experience requirements).

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6.7.1.2 The speech/language pathology assistant's performance of assigned duties.

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6.7.1.3 Ensuring that the speech/language pathology assistant is assigned only duties and responsibilities for which the speech/language pathology assistant has been specifically trained and which he or she is qualified to perform.

6.7.1.4 Ensuring that individuals who will be receiving services from a speech/language pathology assistant, or the individual’s legal representative, is informed that services are being rendered by a speech/language pathology assistant.

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6.7.1.5 Providing appropriate supervision of the speech/language pathology assistant.

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6.8 Supervision of speech/language pathology assistant

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6.8.1 Requirements for supervising speech/language pathologist.

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6.8.1.1 ~~At any given time, the supervising speech/language pathologist may supervise up to two speech/language pathology assistants but not more than one speech/language pathology assistant practicing under a temporary license. As the supervisory responsibility of the speech/language pathologist increases, the clinical responsibilities of the speech/language pathologist must decrease. A speech/language pathology assistant may have multiple supervisors.~~

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Deleted: shall not supervise more than two speech/language pathology assistants at any given time.

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6.8.1.2 Prior to supervising a speech/language pathology assistant, a supervising speech/language pathologist shall have at least 3 years of clinical experience after receiving permanent licensure.

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6.8.1.3 Prior to supervising a speech/language pathology assistant, a supervising speech/language pathologist shall obtain a minimum of 3 hours of continuing education on supervision.

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6.9 Supervision of speech/language pathology assistant after issuance of permanent license.

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6.9.1 ~~The speech/language pathology assistant shall receive a minimum of 10% direct supervision from the supervising speech/language pathologist, with the balance of hours worked under indirect supervision.~~

6.9.2 The amount and type of supervision required shall be based on the skills and experience of the speech/language pathology assistant, the needs of the patients/clients served, the service setting, the tasks assigned and other relevant factors.

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Deleted: 6.109.1 Every 12 weeks, the speech/language pathology assistant shall receive direct supervision from the supervising speech/language pathologist for a minimum of 10 hours, with the balance of hours worked under indirect supervision.

6.10 The speech/language pathology assistant shall maintain a supervision log on a board-approved form. The speech/language pathology assistant shall produce the supervision log in the event that he or she is selected for biennial audit.

6.11 Continuing Education: Speech/language pathology assistants must comply with the continuing education (“CE”) requirements set forth in Board Rule 8.0, except that speech/language pathology assistants must obtain a minimum of 20 CEs each two-year license renewal period. There is no CE requirement for a license issued for less than one year. If a license would cover more than one year, but less than 2 years, the speech/language pathology assistant is required to obtain 10 CEs.

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6.2.2 An applicant shall have completed at least the following course work:

6.2.2.1 General education, shall consist of a minimum of 20 college level semester credit hours, including at least three credit hours in each of the following areas:

Oral and written communication

Mathematics

Computer applications

Social and natural sciences

6.2.2.2 Technical education shall consist of a minimum of 20 college level semester credit hours, including at least three credit hours in each of the following areas:

Overview of normal speech-language development

Overview of communication disorders

Cultural and linguistic factors in communication

Work place behaviors, including ethics

Assistant level service delivery practices

where the applicant did not attend a speech/language pathology assistant program,

A plan for clinical experience shall be prepared and signed by the supervising speech/language pathologist.

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