



# DISABILITIES LAW PROGRAM

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## MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Legislative & Regulatory Initiatives

Date: July 15, 2013

I am providing my analysis of four (4) regulatory and two (2) legislative initiatives for the consideration of the Council's P&L or Executive Committee. Given time constraints, the commentary should be considered preliminary and non-exhaustive.

1. DSS Final Food Supp. Program Time Limit Regulation [17 DE Reg. 66 (July 1, 2013)]

The SCPD and GACEC commented on the proposed version of this regulation in May. A copy of the SCPD's May 30, 2013 memo is attached for facilitated reference.

The Councils endorsed the proposed regulation subject to consideration of one (1) amendment. The Division of Social Services has now acknowledged the commentary, added the Councils' suggested amendment, and adopted a final regulation with no further changes.

Since the regulation is final, and DSS incorporated the Councils' suggested amendment, I recommend no further action.

2. DSAMH Final MH Screener & Vol. Admission Payment Reg. [17 DE Reg. 72 (July 1, 2013)]

The SCPD and GACEC commented on the proposed version of this regulation in May. A copy of the SCPD's May 30 memo is attached for facilitated reference. The Division of Substance Abuse & Mental Health acknowledges receipt of the SCPD's memo but overlooks the GACEC's May 28 letter with the identical commentary.

First, the Councils recommended inserting "Delaware-licensed" prior to "psychiatrist" to clarify that only a Delaware-licensed psychiatrist may authorize detention for a psychiatric evaluation. DSAMH declined to effect the amendment based on the rationale that "(o)nly a licensed physician may practice as a psychiatrist in Delaware".

Second, the Councils recommended revised references to five (5) sections related to detention. DSAMH amended the references in the five (5) sections.

Since the regulation is final, and DSAMH addressed each of the Councils' comments, I recommend no further action.

### 3. DFS Prop. Child Placing Agency Regulation [17 DE Reg. 62 (July 1, 2013)]

The Division of Family Services proposes to adopt a revamped "child placing agency" regulation. The proposed initiative is approximately fifty (50) pages in length and incorporates comprehensive standards.

I have the following observations.

1. In §4.0, definition of "Adoptive Parent", the word "means" is omitted. It should be inserted.

2. In §4.0, definition of "Child Appointed Special Advocate", substitute "litem" for "lite". I also recommend substituting "neglected or dependent child" for "neglected and dependent child" since the terms are disjunctive, i.e. a child can be either abused, neglected, or dependent.

3. In §4.0, the definition of "Developmentally Appropriate" could be improved. The current definition only addresses age and omits any consideration of other characteristics, including disability. As a result, §73.0 would literally require a foster parent to provide a 10 year old child with severe cognitive limitations to use only a fifth-grade reading level book. In contrast, the child's service plan is expected to reflect disability-related considerations. See §§62.1.2 and 62.1.4. Consider the following revision: "Developmentally Appropriate" means...age, is consistent with the child's special needs, and encourages development..." The term "special needs" is defined in §4.0.

4. In §6.1.1, there is a dangling conjunction ("and").

5. Section 12.0 contemplates the posting of a license "at an Agency location". Section 8.1 indicates that a license is issued "for the address of the Agency's actual site where services are being provided." The Division could consider amending §12.0 so the license would be posted at the actual licensed site rather than any agency location.

6. Section 16.0 allows licensees to request a "variance" or waiver of specific standards. It would be preferable to include some provision for notice to affected individuals (e.g. foster and adoptive parents; foster children) to facilitate input. Compare 16 DE Admin Code 3310, §12.1.4; and 16 DE Admin Code 3301, §9.1.5.

7. In §18.0, it would be preferable to include a provision disallowing retaliation against individuals both initiating or cooperating with a complaint investigation. Compare analogous §44.3 and 16 DE Admin Code 3320, §19.2.

8. Section 18.3 requires DFS to categorically notify the licensee and agency that a complaint is being investigated. DFS may wish to reconsider this no-exceptions requirement. Such notice may prompt a wrongdoer to initiate “cover-up” action. Such notice could also compromise a criminal investigation initiated under §18.7. DFS may wish to consult the Attorney General’s Office concerning this provision.

9. In §19.0, DFS could consider requiring notice of incidents involving “exploitation” of a child. See §75.0. DFS could also review analogous regulations to broaden the scope of reportable incidents. See, e.g., 16 DE Admin Code 3320, §24.0; and 16 DE Admin Code 3225, §19.7, including elopement and attempted suicide as reportable incidents.

10. Section 19.2.6 and 101.10 allow facilities to maintain a temperature of 85 degrees. This standard is assessed “at floor level” (§101.10). Since hot air rises, this means that the ambient room temperature may be significantly hotter than 85 degrees. Moreover, Delaware’s high humidity levels exacerbate the effects of high temperatures. Query whether maintaining an infant in a high-humidity room with ambient room temperature between 85-90 degrees is a prudent regulatory standard. Compare 16 DE Admin Code 3225, §17.3 (maximum 81 degree temperature); 16 DE Admin Code 3310, §5.4 (temperature and humidity “provide a comfortable atmosphere”). In other contexts, the Regulation recognizes that children should be accorded some choice in “comfort” contexts. See, e.g., §77.5.4 (authorizing substitution of foods subjectively “disliked” or “unacceptable”) and §81.4 (allowing children to keep personally “special” belongings). DFS could incorporate analogous consideration of a child’s temperature tolerances as well. Compare 16 DE Admin Code 3225, §17.3 (“A resident with an individual temperature-controlled residential room or unit may heat and cool to provide individual comfort.”). At a minimum, the 85 degree standard should be lowered.

11. Section 42.4 is somewhat “overbroad”. It bars employment “in any capacity” of “any person convicted of...offenses against a child”. This bar would apply to individuals with no contact with children (e.g. accountant). This bar would apply to convictions remote in time and irrespective of rehabilitation. There is no definition of “offense against a child” which could be construed to include minor offenses and offenses not implicating child abuse/neglect. Although some discretion for exceptions is authorized by §42.6.6.1, that subsection ostensibly is only applicable to §42.6, not 42.4.

12. Section 42.6 would literally require the licensee to fire anyone “indicted” but not convicted of certain offenses. This is ostensibly inconsistent with federal guidance shared with DFS in connection with commentary on its proposed regulation published at 16 DE Admin Code (May 1, 2013). The Council included the following italicized commentary on that regulation:

*Eighth, §7.0 is “overbroad”. For example, §7.1.1.1 contemplates consideration of arrest records without conviction. This is inconsistent with recent EEOC guidance. See attachments. Consistent with the EEOC Q&A document, Par. 7, the Enforcement Guidance preempts inconsistent state laws and regulations. In the analogous context of adult criminal background checks, the DLTCRP recently adopted the following regulatory standard deferring to the EEOC guidance:*

*8.3. DHSS adopts the guidance from the Equal Opportunity Commission, Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964, 915.002, issued 4/25/2012.*

*16 DE Admin Code 3105, §8.3.*

13. Section 44.4 categorically bars notification of parents of investigation of abuse or neglect in which their child was allegedly victimized: "Staff shall not contact the parent/guardian of a child who is the alleged subject victim to advise them that either a report has been made or that the Division or law enforcement officer is conducting an investigation of an allegation of abuse or neglect." It is "odd" to bar notice to a parent of alleged abuse/neglect of a child. Indeed, the bar is "at odds" with §71.1 which requires the licensee to report to a parent any "incident involving serious bodily injury or any severe psychiatric episode involving the child". Parents will be justifiably upset if agencies conceal information about abuse/neglect of their children.

14. DFS may wish to consider transferring the concepts embodied in §75.0 to §44.0.

15. Section 78.1.4 ostensibly authorizes "locking a child in a room" as long as not "for a long period of time". This is highly objectionable. The Division should bar locking a child in a room.

16. Section 76.1.6 could be embellished with conduct (e.g. throwing child; hitting with closed fist) prohibited by Title 11 Del.C. §468(1)c.

17. Section 78.0 occasionally uses the terminology "is prohibited" (§78.1.9) but generally uses the terminology "shall be prohibited". I recommend generally using present tense, i.e., "is prohibited". Otherwise, it appears that the conduct will be barred in the future.

18. In §78.1.12, insert 'disability' after "family".

19. Section 78.0 could be improved by including a bar on chemical restraint. Compare recently enacted S.B. No. 100 . See also 16 DE Admin Code 3320, §20.11.11.

20. DFS should review both S.B. No. 100 and 16 DE Admin Code 3320, §20.11 for examples of limitations on behavior management that could be incorporated into §78.0.

21. In §80.2, substitute "places" for "place".

22. In §80.5 or §72.0 , DFS may wish to address the use of bumper pads in cribs. See <http://pediatrics.about.com/od/babyproducts/a/crib-bumpers.htm>.

23. In §86.4, DFS should consider insertion of the word “approaching” prior to “eighteen”. As reflected in §86.3, providing a list of community services as the individual is “walking out the door” on the individual’s 18<sup>th</sup> birthday is not prudent. DFS should also consider adding other preparation/orientation activities, including completion of selective service registration. I recommend that DFS review the findings in the preamble to H.B. No. 163 for insight. For example, if 82% of males exiting foster care are arrested by age 21, and a high percentage of females become pregnant by age 21, doesn’t it make sense to address prevention activities?

24. Section 90.1 is somewhat “overbroad” since it does not address the passage of time or rehabilitation. If the substantiated neglect occurred 30 years ago, and the individual is now highly responsible, does it make sense to apply a categorical bar to serving as a foster parent?

25. Section 95.1 categorically bars anyone over sixty-five (65) years of age becoming a foster parent. If there is no State statute which imposes such a limit, any State regulation limiting eligibility in a federally-funded program may run afoul of the federal Age Discrimination Act. See <http://www.hhs.gov/ocr/civilrights/resources/factsheets/age.pdf> and <http://www.dol.gov/dol/topic/discrimination/agedisc.htm>. It is also anomalous that the Regulation contains no age limit for prospective adoptive parents. See §140.0.

26. Although there is a brief treatment of “pets” in §112.0, potentially dangerous pets are not covered in §112.0 or in §101.0. Thus, a prospective foster parent could conceal ownership of multiple pit bulls or snakes. The regulatory standards do not contemplate any inquiry on the safety aspects of pets, only other household members (§§90.2 and 136.4) and visitors (§124.0). DFS may wish to add a standard addressing potentially dangerous pets.

27. The Councils previously questioned the general ban on children wearing a helmet around playground equipment. See §103.2.4.3. I continue to question the rationale for the general ban. Intuitively, if a child falls from a height, the helmet would provide some protection from TBI.

28. Section 113 literally would not require someone driving a child in a pickup truck or van to have a driver’s license and insurance. Consistent with §113.0, consider substituting “vehicle” for “automobile”.

I recommend sharing the above observations with the Division. I also recommend sharing a courtesy copy with the DSAAPD Director, noting the SCPD’s Par. 25 commentary. DSAAPD may wish to comment on this aspect of the Regulation as well by the August 6 deadline.

#### 4. DMMA Prepublication PDN Policy

Background on this initiative is contained in the attached September 16, 2011 SCPD letter. In a nutshell, the DLP and councils reached consensus with DHSS in 2009 to not rigidly apply historical caps on private duty nursing (PDN) hours. Dialog was also initiated on some related matters (e.g. carryover of hours). In November, 2010, DMMA provided a proposed draft of a revised PDN policy to the SCPD. The SCPD provided comments through the attached September 16, 2011 letter. DMMA replied in November, 2012 with responses to the SCPD comments and a new draft policy. I have the following observations on the latest draft policy.

1. Overall, the policy is a major improvement over existing standards. The 16 hour PDN cap on children (under age 21) may be exceeded based on the following: 1) avoidance of hospitalization or institutional placement (§1.1.5); or 2) meeting criteria compiled in §5.2. The 8 hour PDN cap on adults (over 21 years old) may be exceeded based on the following: 1) existence of technology dependence (complex tracheostomy care; mechanical ventilation)(§1.1.3); or 2) avoidance of hospitalization or institutional placement (§1.1.5). Since there may be rare cases that do not strictly meet the above standards, there is also a “catch-all” authorization based on “compelling justification ...with written approval of the Medicaid Director (§1.1.6).

2. I recommend that §1.1.1 be amended as follows: “Children...in 1.1.5, 1.1.6, and 5.2. This clarifies that §1.1.6 applies to children.

3. I recommend that §1.1.2 be amended as follows: “Adult..1.1.3, 1.1.5, and 1.1.6”. This clarifies that §1.1.6 applies to adults. In DMMA’s response to the 2011 SCPD comments, DMMA agreed to adopt this language but it does not appear in the actual text.

4. In its response to the SCPD’s 2011 comments, DMMA agreed to substitute “treating” for “admitting” in §1.1.5.. The actual text needs to be amended.

5. Section 5.1.1.1 refers to the E&D Waiver which no longer exists.

6. In its 2011 comments, the SCPD promoted revision of an inflexible, categorical bar on “banking” and “carryover” of hours in §5.1.4. In its response, DMMA indicated that “PDN approved hours are inclusive of occasional variation in hours which may occur in extenuating circumstances.” I assume this means that an individual could occasionally request approval of some additional hours on an expedited basis. By analogy to the attendant services program standards, I continue to recommend some flexibility in using hours within the same week. Literally, §5.1.4 bars even slight variations from day-to-day.

7. In §5.2.5, the last sentence should be revised to read as follows: “PDN...is capable and available.” This is consistent with the second sentence in the section.

8. In §5.2.1, second sentence, insert “for” between “responsibility” and “the child’s care”.

I recommend sharing the above observations with DMMA.

##### 5. H.B. No. 129 (Hospital Restroom Access)

This bill was introduced on May 9, 2013. It passed the House with H.A. No. 1 on June 25, 2013 by a 40-0 vote. It was assigned to the Senate Health & Social Services Committee on July 9, 2013.

Background is provided in House Amendment No. 1. In a nutshell, a 14 year old teen experienced a medical emergency while locked in a hospital restroom. Hospital staff were unable to unlock the door until a security guard arrived. The teen died. Her parents are now promoting enactment of this legislation (earmarked "Christina's Law") to prevent a recurrence of this scenario. The bill requires DHSS to "adopt regulations to ensure that hospital staff have ready access to a locked hospital bathroom in the event of an emergency."

DHSS already enjoys the authority to issue regulations concerning hospitals and safety issues. See lines 3-5 of H.B. No. 129. Thus, DHSS could ostensibly obviate the necessity of the legislation by simply issuing an appropriate regulation. On the other hand, the legislation would result in prioritization of issuance of a "locked bathroom" regulation. My predisposition is to recommend endorsement of the concept of the bill. However, since the Legislature is currently out of session, I recommend that the SCPD first solicit the Department's perspective via Deborah Gottschalk and, if desired, the perspective of the prime sponsor, Rep. Kenton.

#### 6. H.B. No. 154 (Medication Diversion & Drug Abuse Training)

This legislation was introduced on May 30, 2013. It passed the House with H.A. No. 2 on June 25, 2013. On July 9, it was assigned to the Senate Health & Social Services Committee. Enactment requires a 2/3 vote (H.A. No. 2, lines 2-3).

The legislation has multiple purposes, including the following: 1) facilitation of prosecution of perpetrators of abuse, neglect, and mistreatment of residents and patients in licensed long-term care facilities and hospitals; 2) explicit inclusion of "medication diversion" as a form of "abuse"; and 3) promotion of training by healthcare providers in controlled substances and recognition of dependency.

Prosecution of abuse, neglect and mistreatment will no longer require a showing that conduct was "knowing". It will be sufficient if the conduct is "reckless" (line 71). This is a lesser standard. See Title 11 Del.C. §231.

"Medication diversion" is broadly defined (lines 15-19) and is now included in the definition of "abuse" (line 6).

Practitioners registered to prescribe or distribute controlled substances would generally be required to complete continuing professional education related to prescribing/delivering controlled substances or recognizing symptoms of dependency (H.A. No. 2, lines 8-14).

The legislation is well intentioned. However, I have two (2) significant concerns.

First, the scope of criminal liability for “medication diversion” is ostensibly too broad. Literally, if a guardian or person authorized to provide consent to medical treatment [Title 16 Del.C. §§1121(34), 1122, and 2507] withheld or refused to consent to a prescribed medication, they would be guilty of a class G felony (lines 15-19 and 76-77). They would be “interrupting” or “obstructing” the delivery or administration of a prescription drug. The “good faith” exception would be inapplicable since limited to healthcare providers (lines 22-23). Indeed, although the Long-term Care Bill of Rights explicitly authorizes a competent individual to refuse medication [Title 16 Del.C. §1121(4)], the legislation could literally expose a competent individual refusing medication to prosecution since obstructing administration of a prescribed drug (lines 15-19 and 76-77). It would be preferable to exempt refusal to provide consent to prescribed medications from prosecution.

Second, the legislation provides conflicting “state of mind” standards. As defined at lines 15-16, “medication diversion” constitutes “abuse” only if “knowing” or “intentional.” However, another section authorizes prosecution for “abuse” based on “recklessness” (lines 71-72). A third section authorizes prosecution for medication diversion if “knowing” (omitting “intentional” and “reckless” states of mind). This lack of consistency may result in confusion.

I recommend sharing an endorsement of the concept of the bill subject to consideration of the above concerns.

#### Attachments

8g:legis/713bils  
F:pub/bjh/legis/2013/713bils



STATE OF DELAWARE  
STATE COUNCIL FOR PERSONS WITH DISABILITIES

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MEMORANDUM

DATE: May 30, 2013

TO: Ms. Sharon L. Summers, DSS  
Policy, Program & Development Unit

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

RE: 16 DE Reg. 1143 [DSS Proposed Food Supplement Program Time Limit Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Social Services' (DSS) proposal to amend its Food Supplement Program regulation in the context of time limits for "Able-bodied adults without dependents". The proposed regulation was published as 16 DE Reg. 61143 in the May 1, 2013 issue of the Register of Regulations.

The rationale is "to make the rules easier to understand and follow", to add a federal citation, and to change the name of the section to more accurately reflect the content of the policy. The revised regulation generally conforms to the federal regulation, 7 C.F.R. §273.24. The federal regulation implements a federal law limiting receipt of "food stamp" benefits to 3 months in a 36-month period for "able-bodied adults without dependents" (ABAWDs) who are not working or who are not exempt.

SCPD endorses the proposed regulation subject to consideration of a minor revision to §9018.2, Section 4, as follows:

Good cause includes circumstances beyond the individual's control, such as, but not limited to: ...

This would clarify that the subsequent list is illustrative only and more closely conforms to the analogous federal standard, 7 C.F.R. §273.24(b)(2).

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

cc: Ms. Elaine Archangelo  
Mr. Brian Hartman, Esq.  
Governor's Advisory Council for Exceptional Citizens  
Developmental Disabilities Council

16reg1143 dss-food sup program time limit 5-30-13



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MEMORANDUM

DATE: May 30, 2013

TO: Ms. Dara Schumaier, Community Relations Officer  
Division of Substance Abuse & Mental Health

FROM: *D.M. P.*  
Daniese McMullin-Powell, Chairperson  
State Council for Persons with Disabilities

RE: 16 DE Reg. 1148 [DSAMH Proposed MH Screener & Voluntary Admission  
Payment Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Substance Abuse and Mental Health's (DSAMHs) proposal to amend its mental health commitment screening regulation. The proposed regulation was published as 16 DE Reg. 1148 in the May 1, 2013 issue of the Register of Regulations.

The rationale is that, effective July 1, only credentialed mental health screeners can authorize a mental health commitment-related detention. See Title 16 Del.C. §§5121A and 5122. However, the current mental health screener training curriculum does not address children. Therefore, on an interim basis, DSAMH and the Division of Prevention and Behavioral Health Services (DPBHS) would like to authorize psychiatrists and credentialed physicians (but not non-physician screeners) to authorize commitment-related detention of children. This will provide some time to modify the screener curriculum to address children. An April 26, 2013 email from DHSS summarizes this intended approach:

Concerns were also raised about how the changes enacted by HB 311 affect youth, particularly regarding the requirement that only credentialed mental health screeners can decide if someone should be held involuntarily for evaluation. Under current law, youth are evaluated under the same law as adults, thus, the new screener requirement will apply to youth as well. Because the screener curriculum did not anticipate youth, DHSS is publishing a proposed amendment to the HB 311 regulations on May 1. The amendment will allow psychiatrists and credentialed physicians to evaluate people under age 18, but other credentialed screeners may only evaluate adults. This way, if the physicians who are currently doing these evaluations for juveniles get credentialed by June 30<sup>th</sup>, we will

essentially preserve the status quo for juveniles until any new process/requirements are thought through and enacted.

SCPD endorses this approach subject to revised language in the proposed regulation.

First, in §3.1.3, insert "Delaware-licensed" between "A" and "psychiatrist". This would clarify, consistent with Title 16 Del.C. §5122(a)(1)a, that the authorization of a "psychiatrist" to authorize a commitment-related mental health detention does not extend to psychiatrists lacking a Delaware license.

Second, in §§3.1.3, 3.2.4, 3.3.4, 3.43, and 3.5.2, SCPD recommends revised language.

A. The statutory term is "detention", not detainment. See Title 16 Del.C. §5122.

B. Literally, the regulation states that the screener "detains" the individual. This is not accurate. In general, the screener authorizes detention but does not personally physically detain the individual. The screener's certification authorizes designated transport personnel, including police, to "detain" and transport the individual. See Title 16 Del.C. §5122(d) and 5122(a)(6).

C. The relevant statutes do not authorize a screener to "abrogate" a detention or detainment. Once the authorized screener completes the detention form, designated transport personnel promptly take the person to a treatment facility. See Title 16 Del.C. §5122(d). Once there, an independent psychiatrist assesses the patient within 24-72 hours and either discharges the patient forthwith or initiates the involuntary commitment process. See Title 16 Del.C. §5122(f)(g). Indeed, in the case of minors, a DSCY&F designated psychiatrist is authorized to independently determine if a detained minor meets admission criteria. See Title 16 Del.C. §5122(h). Contrary to the proposed regulation, the "screener" cannot rescind a form after formal issuance. This could result in conflicts between the screener and the facility psychiatrist. For example, if the screener "abrogates a detainment" after an individual has arrived at a facility, and the facility staff disagree, whose view controls?

Therefore, SCPD recommends that the above references be changed to "may authorize detention for a psychiatric evaluation".

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

cc: The Honorable Rita Landgraf  
Ms. Kevin Huckshorn  
Ms. Susan Cycyk  
Ms. Deborah Gottschalk  
Mr. Brian Hartman, Esq.  
Governor's Advisory Council for Exceptional Citizens  
Developmental Disabilities Council

## Dangers of Crib Bumper Pads

### Crib Safety Basics

By Vincent Iannelli, M.D., About.com Guide Updated October 18, 2011

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Crib bumpers were made obsolete a long time ago, once infants could no longer fit their head through the wider gap of the slats on older cribs. They continue to be popular, though, and are used by many new parents, often because they continue to be sold as a part of baby bedding sets.

But should you avoid crib bumpers?

#### Crib Bumpers

The Consumer Product Safety Commission (CPSC) says to avoid "pillow-like bumper pads."



Before your baby is born, be sure her crib is safe by taking the blankets, pillows, stuffed toys, and the crib bumper out.

Photo by Vincent Iannelli, MD

Although the American Academy of Pediatrics used to say that "If bumper pads are used in cribs, they should be thin, firm, well secured, and not 'pillow-like,'" they now say that bumper pads are not recommended.

And even before they had a formal policy against the use of crib bumpers, there was advice on the AAP website that recommended that parents not use them because they are just decorative and may lead to rare, but preventable, deaths.

The AAP also warned that crib bumper pads should be removed once your baby begins to stand.

#### Dangers of Crib Bumper Pads

While the CPSC continues to investigate crib bumper pads, parents can decide if crib bumper pads are worth the risk. Originally designed to prevent babies from getting their head through the gap between crib slats, crib bumpers lost much of their real purpose when the crib safety regulations reduced the gap between slats in 1974.

Now they are purely decorative and are often sold as a part of crib bedding sets.

An article published in 2011 in *Pediatrics*, titled "Injuries Associated With Cribs, Playpens, and Bassinets Among Young Children in the US, 1990-2008," stated that "The use of crib bumper pads is strongly discouraged because the possibility for serious injury, including suffocation and strangulation, greatly outweighs any minor injury they may prevent."

Parents should also consider that a recent investigation by the *Chicago Tribune* suggests that deaths from crib bumper pads are likely under-reported.

#### Crib Bumper Safety

Why should crib bumpers be thin, firm, well secured, and not "pillow-like?"

If you do use crib bumpers, this can help to avoid the most common ways that crib bumper pads lead to injuries and death:

- strangulation by crib bumper pad ties
- suffocation against the crib bumper pads
- entrapment against the crib bumper pads and another object, such as the crib slats or crib mattress

Even these crib bumper safety tips won't prevent all injuries, as babies can get entrapped with a firm crib bumper, too.

Would a mesh crib bumper be a safer alternative to traditional crib bumpers? Most likely it would, but so would simply removing or never putting crib bumpers in your baby's crib in the first place.

#### Crib Bumpers - What You Need To Know

Making sure your baby's crib is safe is an important part of [baby proofing](#) your home.

Don't make your baby's crib less safe by adding an unsafe crib bumper to your baby's crib.

To recap, important things to know about crib bumpers include:

- The use of crib bumpers is now discouraged by most safety experts.
- If you do choose to use crib bumpers for decorative purposes, make sure that they are not pillow-like and that they are thin, firm, and well secured to your baby's crib.
- Be sure to remove crib bumpers once your baby is able to stand, so that he can't use them to help climb out of his crib.
- Many people think that deaths from crib bumpers are under-reported.
- The Canadian Paediatric Society and Health Canada have had a formal recommendation against using crib bumpers since 2004.

Parents should also keep in mind that crib bumpers are not thought to be needed to prevent serious injury from infants or toddlers getting their arms or legs caught between crib slats, which is one of the main reasons that they use crib bumpers in the first place.

Sources:

American Academy of Pediatrics Policy Statement. The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variables to Consider in Reducing Risk. *Pediatrics* 2005 116: 1245-1255.

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Yeh, Elaine S. Injuries Associated With Cribs, Playpens, and Bassinets Among Young Children in the US, 1990-2008. *Pediatrics*, Mar 2011; 127: 479 - 486.

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# OFFICE FOR CIVIL RIGHTS

## KNOW ABOUT THE FEDERAL LAW THAT PROTECTS AGAINST AGE DISCRIMINATION

### What is the Age Discrimination Act?

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

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

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

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

### Office for Civil Rights

U.S. Department of Health  
and Human Services

200 Independence Avenue, SW.  
H.H.H. Building, Room 509-F

Washington, D.C. 20201

#### TELEPHONE

1-800-368-1019

#### E-MAIL

[ocrmail@hhs.gov](mailto:ocrmail@hhs.gov)

#### TDD

1-800-537-7697

[www.hhs.gov/ocr](http://www.hhs.gov/ocr)

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

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

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

The following information must be included:

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

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

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

### **To learn more:**

**Visit us online at [www.hhs.gov/ocr](http://www.hhs.gov/ocr)**

**Call us toll-free at 1-800-368-1019**

**Email us: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov)**

**TDD: 1-800-537-7697**

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

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## Equal Employment Opportunity

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### Age Discrimination

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The [Age Discrimination Act of 1975](#) prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements. The Age Discrimination Act is enforced by the [Civil Rights Center](#).

The Age Discrimination in Employment Act of 1967 (ADEA) protects certain applicants and employees 40 years of age and older from discrimination on the basis of age in hiring, promotion, discharge, compensation, or terms, conditions or privileges of employment. The ADEA is enforced by the [Equal Employment Opportunity Commission \(EEOC\)](#).

Section 188 of the [Workforce Investment Act of 1998 \(WIA\)](#) prohibits discrimination against applicants, employees and participants in WIA Title I-financially assisted programs and activities, and programs that are part of the One-Stop system, on the ground of age. In addition, WIA prohibits discrimination on the grounds of race, color, religion, sex, national origin, disability, political affiliation or belief, and for beneficiaries only, citizenship or participation in a WIA Title I-financially assisted program or activity. Section 188 of WIA is enforced by the [Civil Rights Center](#).

### DOL Web Pages on This Topic

[Civil Rights Center](#)

Monitors and enforces the Age Discrimination Act in programs and activities receiving federal financial assistance.

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### Laws & Regulations on This Topic

#### Laws

[29 USC §621](#)

Age Discrimination in Employment

[29 USC §6101](#)

Age Discrimination Act of 1975

#### Regulations

[29 CFR Part 37](#)

Implementation of the Nondiscrimination and Equal Opportunity Provisions of the Workforce Investment Act (WIA)

[29 CFR Part 1625](#)

Age Discrimination in Employment Act — Interpretations

[29 CFR Part 1626](#)

Procedures. Age Discrimination Act



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

September 16, 2011

Ms. Rosanne Mahaney, Director  
Division of Medicaid & Medical Assistance  
Lewis Building  
Herman Holloway Campus  
1901 N. DuPont Highway  
New Castle, DE 19720

RE: DMMA Draft PDN Provider Specific Policy

Dear Ms. Mahaney:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) draft private duty nursing (PDN) regulation. SCPD certainly appreciates the opportunity to comment and apologizes for the delay in providing the commentary to the Division.

As background, in 2005 Department of Health and Social Services (DHSS) issued a comprehensive regulation addressing Medicaid coverage of PDN services. SCPD, the Developmental Disabilities Council (DDC), and the Governor's Advisory Council for Exceptional Citizens (GACEC) submitted extensive comments which prompted several amendments. However, there remained some contexts of concern to the Councils, including weekly caps on PDN hours (8 hours for adults and 16 hours for children); and bar on "banking" or "carrying over" hours. In May of 2009, the Disabilities Law Program (DLP) challenged the no-exceptions 8-hour cap on PDN on behalf of a twenty-nine year old with Duchenne muscular dystrophy with a peg feeding tube and tracheotomy with a primary diagnosis of ventilator dependent respiratory failure. A DMMA hearing officer upheld the no-exceptions 8-hour cap on PDN irrespective of need. The DLP appealed that decision to Superior Court. Consistent with the attached article, the application of such caps is a national problem which has prompted litigation in other states. A common scenario is an individual receiving 16 hours of PDN under the children's cap being threatened with institutionalization when reaching age 21 in states with no or reduced PDN for adults.

In August, 2009, Council and DLP representatives met with DHSS representatives to review concerns with limited access to PDN. An informal agreement was reached to interpret an existing regulation as authorizing an exception to the 8-hour PDN cap for adults:

5.3.3: An increase in hours may be approved if additional hours will avoid hospitalization or institutional placement as a cost effective measure. This will depend on the medical necessity, the amount of additional hours needed and the letter of medical necessity from the admitting physician.

This interpretation was an interim approach pending development of revised regulations. In practice, technologically dependent adult Medicaid beneficiaries are currently provided more than 8 hours of PDN if necessary to avoid institutionalization based on that regulation. Given the change in practice, the DLP withdrew its appeal of the adverse hearing officer decision. In the Fall of 2009, DMMA established a work group to undertake a comprehensive revision to its PDN standards and the Division then shared the draft standards in November 2010. SCPD is now providing the following analysis of the draft regulations.

§§1.0 and 5.1: The "Overview" section includes a salutary provision requiring MCOs to provide PDN consistent with the policy. However, MCOs were historically responsible only for the first 28 hours of PDN per week. See 8 DE Reg. 1303, 1306, Section 1.0 (March 1, 2005). This limit is absent from the policy. Perhaps it has been superseded by changes in the Diamond State Health Plan Plus (DSHPP). Moreover, §5.1 contemplates DSAAPD or DMMA nursing approval of PDN exclusively rather than an MCO nurse. The policy does not address MCO authorization of PDN. The current responsibility of MCOs should be clarified in the contexts of number of hours and authorization. In a similar context, the policy covers PDN covered under the E&D waiver. See §5.1.1.1. Normally, a waiver has its own utilization limits and standards. If the waiver standards differ from the draft policy, they will have to be reconciled to conform.

§§1.0 and 1.1.1: These sections convey inconsistent messages. On the one hand, §1.1.1 establishes a PDN cap of 16 hours for children under age 21. On the other hand, §1.0 recites that such limits are ignored if more services are medically necessary. Under the Medicaid program, all services must be medically necessary. This approach is confusing and will predictably lead to disparities in application of the policy. DMMA could consider the following alternative approaches. First, it could simply delete the 16-hour cap in §1.1.1. Second, since relatively few children will need more than 16 hours of PDN, consider the following:

- 1.1.1. Children under age 21 are eligible for up to sixteen hours of PDN daily. This presumptive limit is subject to exception based on either:
  - 1.1.1.1 meeting the criteria of §1.1.5;
  - 1.1.1.2 meeting the criteria of §5.2.3;
  - 1.1.1.3 meeting the criteria of 5.2.6; or
  - 1.1.1.4 based on compelling justification, securing the written approval of the Medicaid Director or designee.

The addition of §1.1.1.4 provides some additional flexibility to DMMA since compelling circumstances apart from institutionalization could arise (e.g. sudden, temporary, unexpected illness or injury of caregiver). The addition of §1.1.1.2 clarifies the interplay between §5.2.3 and this section.

§§1.1.2 and 5.2.3 and 5.2.6:

A. The 2009 hearing officer decision opined that the (currently renumbered) §1.1.5 did not apply to adults. It is therefore critical to clarify DMMA's regulatory intention that §1.1.5 does authorize an exception to the 8-hour adult limit in §1.1.2.

B. It is important to clarify that §1.1.3 is an exception to §1.1.2.

C. The rationale for the exception in §5.2.3 would logically apply to both caregivers of children and adults. Therefore, §5.2.3 should be amended by substituting "individual" for "child".

D. The rationale for the exception in §5.2.6 would also apply to adult day programs. Section 5.2.6 should be revised to include adults unable to attend a day program due to sickness, closure, or inclement weather.

Similar to the above recommended children's standard, SCPD recommends amending §1.1.2 as follows:

- 1.1.2. Adult Medicaid clients age 21 and over are eligible for up to eight hours of PDN daily. This presumptive limit is subject to exception based on either:
- 1.1.2.1 meeting the criteria of §1.1.3;
  - 1.1.2.2 meeting the criteria of §1.1.5;
  - 1.1.2.3 meeting the criteria of §5.2.3;
  - 1.1.2.4 meeting the criteria of §5.2.6; or
  - 1.1.2.5 based on compelling justification, securing the written approval of the Medicaid Director or designee.

§1.1.3.2: SCPD realizes it does not have an expertise in this area; however, the proposed DMMA policy is ostensibly "underinclusive" in the context of technology dependency and too strict in addressing tracheostomy needs. The attached Washington State policy, for example, includes consideration of "complex respiratory support" apart from a tracheotomy, including "application of respiratory vests" and "intermittent positive pressure breathing" which do not appear within the DMMA policy. Moreover, the DMMA policy requires that all 6 bullets under this subsection be met. Thus, if someone needed suctioning every hour (6<sup>th</sup> bullet) but only needed nebulizer treatments 3 times a day, the person would not qualify for more than 8 hours of PDN. Likewise, the DMMA policy does not address intravenous/parenteral administration of medications or nutritional substances on a continuing or frequent basis in contrast to the Washington State policy.

§1.1.5: The reference to "admitting" should be deleted. PDN is not provided within facilities. See §1.1.6.

§5.1.4: This subsection categorically precludes all "banking" or "carryover" of hours not used in one day. DHSS has been adopting more flexible standards in similar programs. For example, the DHSS Personal Attendant Services (PAS) program allows flexibility in use of hours within the same pay period. The attached PAS Service Specifications recite as follows:

4.11 The use of flexed hours within the same time period is permitted. No hours can be "borrowed" or "advanced" in anticipation of paying them back through flexing at a later date.

4.12 Additional short term attendant services hours may be authorized for consumers if determined eligible by the DSAAPD Case Manager.

[emphasis supplied]. It would be preferable for the PDN standards to incorporate a similar approach.

In their 2005 comments on the previously numbered subsection, the Councils commented as follows:

(T)he regulations are unduly constrictive in the context of "carryover". See Sections 5.1.5 and 5.2.9. The standards explicitly disallow carryover even to the next day. A completely rigid and inflexible system is simply not realistic and will result in hardship to families. Recognizing that a weekly schedule is developed at a minimum, consider the following alternative to Section 5.2.9:

DSS projects a sufficient number of hours per day. If the hours authorized are not used on a particular day, the hours do not generally carryover to the next day or weekend nor can the hours be "banked" to be used at a later time. Occasional variations of 3 hours or less within a week based on unexpected or extenuating circumstances may be acceptable.

8 DE Reg. 1303, 1305. Consistent with the above commentary, DMMA could revise the proposed §5.1.4 as follows:

5.1.4. PDN hours must be used for the period of time in which they are authorized. If the hours authorized are not used on a particular day, the hours do not generally carry over to the next day or weekend nor can the hours be "banked" to be used at a later time. Occasional variations of 3 hours or less within a week based on unexpected or extenuating circumstances may be approved.

§5.2.1: In the second sentence, SCPD believes DMMA intended to insert the word "for" between "responsibility" and "the". However, there is some "tension" between a requirement of a "capable" caregiver and the ADA. There may be caregivers who are elderly or insufficiently capable/sophisticated to provide technical or physical care. They may not be able to physically lift a Medicaid patient due to their own disability. However, they may have the wherewithal to supervise the provision of care. Query whether a no-exceptions policy of caregiver capacity may violate the "reasonable accommodations" provisions of the ADA.

§5.2.4: SCPD recommends adding the following sentence: "The consent of the child's parent or guardian is required to authorize school-related PDN." Under the IDEA, schools cannot force parents to use public or private insurance to provide a FAPE and must obtain parental consent to access a child's Medicaid. See attached OSEP Policy Letter to Dr. O. Spann, 20 IDELR 627

(September 10, 1993). There may be parent-school "conflict" situations in which DHSS or an MCO authorizes only a limited number of PDN hours and the school wishes to "take" a disproportionate share of the overall approved hours. In the event of a disagreement, the parent/guardian's decision prevails over the school's wishes.

§5.2.5: Consistent with the discussion of §5.2.1 above, there may be circumstances in which a parent/caregiver is not capable of independently transporting a child to and from medical appointments. For example, there may be technology at home to assist the parent/caregiver in providing care which is not available in-transit. Alternatively, a parent may be capable of suctioning a stable child in bed but be unable to suction the same child in a moving vehicle jostling the passengers up and down and side to side. The last two sentences of this subsection are too rigid.

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

Sincerely,



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

cc: Ms. Rita Landgraf  
Ms. Debra Gottschalk  
Mr. Dave Michalik  
Ms. Sharon Summers  
Mr. Brian Hartman, Esq.  
Governor's Advisory Council for Exceptional Citizens  
Developmental Disabilities Council

p&l/regs/dmma pdn reg 9-16-11

CMS, from previous page

### CourtWatch Update: Good Decisions for People with Disabilities

In recent months, advocates have been cheered by several positive federal court decisions for people with a variety of disabilities. These victories have been welcome news, considering the mixed success of cases filed to enforce the Americans with Disabilities Act (ADA) in the past several years.

Two similar cases in Illinois and Oklahoma involve young adults with severe physical disabilities. Both received benefits through Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for individuals under age 21. Under EPSDT, children and youth are entitled to all Medicaid services necessary to "correct or ameliorate" their physical and mental disabilities and conditions, regardless of whether those services would be covered for adults 21 and over. In *Radaszewski v. Marum*, Illinois' Medicaid program had covered sixteen hours of in-home nursing services per day for Eric Radaszewski. When he turned 21 and was no longer entitled to EPSDT, his coverage would be reduced to five hours per day. It was undisputed that this reduction would place Eric at imminent risk of institutionalization in a nursing home. Moreover, living in a nursing home would be very dangerous for him because he could not receive the individual attention needed for his condition.

The court held that Illinois' Medicaid agency's refusal to provide the care Eric needed in the community violated the ADA and Section 504 of the Rehabilitation Act. Specifically, forcing him into a nursing home to receive the care that he needed violated the two statutes' requirement that services be provided in the most integrated setting appropriate. The court held that providing care in the community could be reasonably accommodated even taking into account Illinois' resources and the needs of others with disabilities. It noted that the cost of caring for Eric in the community would actually be less than care in a hospital and that the state could request a waiver from the federal government to enable it to provide services in the

community. Prairie State Legal Services represents the plaintiff in this case. As of press time, the state had not appealed the decision.

In the Oklahoma case *Easton v. Fogarty*, the plaintiff, Lindsey Easton, has severe physical disabilities as a result of a rare form of muscular dystrophy. As a result, she is ventilator-dependent and needs nursing services around the clock. Despite her severe limitations, however, she was valedictorian of her high school class. She was able to live at home because Oklahoma Medicaid covered 16 hours of nursing services per day through EPSDT. Lindsey and her family were told that the nursing services would be terminated when she turned 21, because Oklahoma did not cover in-home nursing services for adults. Before her birthday, Lindsey sued for violations of the ADA and Section 504's community integration requirements. She also filed for a temporary restraining order to halt the termination of services. Before the court could hear the case, however, the state agreed not to terminate the services while the case was pending. The case will continue. The attorney representing Lindsey is Steven A. Novick of Tulsa.

Federal courts in New York and Florida considered disability discrimination claims on behalf of groups living in nursing homes. In *Joseph S. v. Hogan*, the plaintiffs sued on behalf of individuals with mental illness discharged from psychiatric hospital settings to nursing homes. They claimed that New York was not providing services in the most integrated settings appropriate, in violation of the ADA and Section 504. They also argued that Medicaid provisions governing placement in nursing homes were violated. Attorneys for the state argued that the case should be dismissed, but the court refused to dismiss the ADA and 504 claims. It also held that the Medicaid provisions were enforceable, although it dismissed some Medicaid claims based on events that happened too far in the past.

The analysis and decision in this case were made by a magistrate judge and were adopted by the district court judge on May 23. The case will continue. Disability Advocates, Inc., Schiff Hardin, New York Lawyers in the Public Interest, and Mental Hygiene Legal Services are counsel for the plaintiffs.

*Long v. Benson* was filed in federal court in Florida on behalf of people living in nursing homes who are capable of and wish to live in the community. These people's disabilities are not severe and could live safely in their homes

CONFIDENTIAL/COMPLIANCE MATTER

or community settings with appropriate supportive services. Thus, forcing them to live in nursing homes to receive services violates the ADA and Section 504. Attorneys for Florida argued that the case should be dismissed because, among other reasons, the regulations requiring that services be provided in the least restrictive setting and that states make reasonable accommodations for people with disabilities were invalid. The court rejected this and all of the state's other arguments and the case will continue. The plaintiffs are represented by Southern Legal Counsel, Steve Gold, AARP Foundation Litigation and the National Health Law Program.

For decisions or pleadings in any of these cases, contact Sarah Somers at [somers@healthlaw.org](mailto:somers@healthlaw.org)

**Eligibility for PDN Services**  
**Who determines eligibility for PDN?**

- For HCS clients, the Community Nurse Consultant determines eligibility for PDN.
- For DDD clients age 18 and older, the Nursing Care Consultant determines eligibility for PDN.

**What makes a client eligible for PDN Services?**

Clients must meet medical, financial and program eligibility requirements. Financial and program eligibility may be completed concurrently; however, **PDN cannot begin until financial eligibility is established.** (WAC 388-106-1010)

(1) **Financial Eligibility:** Verify that the client meets financial eligibility requirements, which means the client is Categorically Needy (CN) or Medically Needy (MN). **NOTE:** A client does not have to participate toward their PDN, but must participate toward personal care depending on their income. In HCS, the financial worker will provide you with the participation information. In DDD, the Case Resource Managers calculates the participation information.

Financial Requirements for PDN clients	
Program	Requirements
COPEs	The client <u>does not</u> participate toward PDN. The client <u>does</u> participate toward waived services they are eligible for. Income cannot be above the COPEs SIL (Special Income Level)
MPC - CN	The client <u>does not</u> participate toward PDN or any personal care they are eligible to receive. The client <u>does</u> participate toward room and board in an AFH. (A client cannot receive PDN in any other residential setting)
CN / not receiving MPC	The client <u>does not</u> participate toward PDN. The client <u>does</u> participate toward cost of care in an AFH (A client cannot receive PDN in any other residential setting).
MN - Regular	Spend down may be required and the client <u>can use</u> PDN for spend down, but neither <u>MN nor PDN services can be</u> authorized until spend down is met.
MN - Waiver	The client <u>does not</u> participate toward PDN. The client <u>does</u> participate toward the cost of personal care for in-home and AFH services. (A client cannot receive PDN in any other residential setting.)
CORE Waiver - In-Home	The client <u>does not</u> participate toward PDN.
Basic Plus In Home	The client <u>does not</u> participate toward PDN.

(2) **Functional Eligibility:** You must complete a face to face CARE assessment every six months. [WAC 388-106-1030 (1)]. That assessment and the Skilled Nursing Task Log (SNTL) must verify that the client:

1. Requires care in a hospital or meets Nursing Facility Level of Care;
2. Has unmet skilled nursing needs that cannot be met in a less costly program or restrictive environment; and
3. Is unable or unwilling to have their care tasks provided through nurse delegation, COPES Skilled Nursing, or self-directed care; and
4. Has a complex medical need that requires four or more **continuous** hours of skilled nursing care which can be safely provided outside an institution. (Note: The need for a nursing assessment does not qualify a person for PDN); and
5. Is technology-dependent daily, meaning:

<b>Functional Requirements for technology-dependent PDN clients</b>	
<i>Skilled Task</i>	<i>Description</i>
A. Mechanical Ventilation	The client requires the use of a mechanical device.
B. Complex respiratory support	Complex respiratory support means that: <ul style="list-style-type: none"> <li>o The client requires <b>two</b> of the following treatment needs at least one time in a four continuous hour period:                             <ol style="list-style-type: none"> <li>i. Postural drainage and chest percussion; or</li> <li>ii. Application of respiratory vests; or</li> <li>iii. Nebulizer treatments with or without medications; or</li> <li>iv. Intermittent Positive Pressure Breathing; or</li> <li>v. O2 saturation with treatment decisions dependent on the results; <b>AND</b></li> </ol> </li> <li>o The client's treatment needs must be assessed and provided by an RN or LPN; <b>AND</b></li> <li>o The client's treatment needs cannot be nurse delegated or self-directed.</li> </ul>
C. Tracheotomy	The client requires sterile suctioning at least one time in a four continuous hour period.
D. Intravenous/parenteral	The client requires intravenous/parenteral administration on a continuing or frequent basis.

administration of multiple medications	
E. Intravenous administration of nutritional substances.	The client requires intravenous administration on a continuing or frequent basis.

6. Requires skilled nursing care that is medically necessary, as defined by the client's physician; and
7. Is able to supervise the care provider(s) or has a guardian who supervises care; and
8. Has family or other appropriate supports who assume a portion of the care; and
9. Does not have other resources or means for providing this service.

**Primary care provider approval:** Have a primary provider document in the PDN provider's plan of care:

- The client's medical stability;
- The client's appropriateness for PDN care;
- Approval of the PDN provider's plan of care; and
- Orders for medical services.

**SERVICE SPECIFICATIONS #X**  
Revised 4/24/09

**PERSONAL ATTENDANT SERVICES**

**1.0 SERVICE DEFINITION**

- 1.1 Personal Attendant Services (PAS) provides support to adults with physical disabilities who require assistance with the functions of daily living, self-care or mobility in order to maximize their independence in the community. This service relies on the consumer's ability to self direct.
- 1.2 A consumer may act through a guardian or appointed representative.
  - 1.2.1 The guardian or appointed representative for the consumer may not be hired as his/her personal attendant.
- 1.3 The consumer shall be supported in his/her effort to direct services contained in the consumer's Individual Services Plan (ISP) as outlined in the specifications.

**2.0 SERVICE UNIT**

- 2.1 The standard service unit is one hour of service provided by an attendant to an eligible consumer.
- 2.2 The minimum billable unit of time is one quarter hour of service.
- 2.3 Travel to and from the consumer's home (or initial service site) shall not be included.

**3.0 ELIGIBILITY**

- 3.1 The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) Case Manager will determine consumer eligibility for PAS and approve the amount of weekly units authorized for service. Approval will be based upon needs and proposed usage of the attendant(s). The DSAAPD Case Manager and consumer will jointly determine the units required.
- 3.2 Criteria that the DSAAPD Case Manager will use to determine consumer eligibility include, but are not limited to, the following:
  - 3.2.1 residency in the State of Delaware
  - 3.2.2 age 18 years or older
  - 3.2.3 presence of a severe, chronic physical disability which precludes or significantly impairs the individual's independent performance of essential activities of daily living, self-care or mobility within home or community environments. For purposes of this section, a "chronic disability" is a medically determinable impairment which can be expected to last for a continuous period of not less than 12 months.

**4.0 SERVICE STANDARDS**

- 4.1 The provider agency must meet and comply with all applicable federal, state and local rules, regulations and standards applying to the services being provided.
- 4.2 Within 45 working days of referral, the provider agency and the consumer shall negotiate and sign an Individual Service Plan (ISP) based on the consumer's needs, proposed usage of the attendant(s) and the units of service as determined by the consumer and DSAAPD during the eligibility determination.
- 4.3 The ISP shall contain the following:
  - 4.3.1 for the initial ISP, goals for service, as developed between the DSAAPD Case Manager and consumer and as defined on the Service Referral Form.
  - 4.3.2 a description of the services to be provided and how they will be provided;
  - 4.3.3 the time and number of service units (hours) to be delivered
  - 4.3.4 a description of priority care and the viable back-up plan.
  - 4.3.5 a section showing the following:
    - 4.3.5.1 Name and the relationship of the regular attendant(s) and the backup attendant(s).
    - 4.3.5.2 Name, relationship, and notation of other paid or unpaid support persons in the home
    - 4.3.5.3 Number of hours scheduled per pay period;
    - 4.3.5.4 Listing of other employment obligations of attendant(s) or backup attendant(s).
    - 4.3.5.5 Any unique circumstances or conditions;
  - 4.3.6 confirmation of the completion of attendant and/or consumer training;
  - 4.3.7 a clearly stated description of the responsibilities of the provider agency, the attendant(s) and the consumer.
- 4.4 This ISP must be submitted to the DSAAPD Case Manager within 10 working days of signature
- 4.5 **Provider Agency Responsibilities:**
  - 4.5.1 **Recruit attendants**
    - 4.5.1.1 Provide basic training for attendants
    - 4.5.1.2 Maintain a roster of available attendants for the consumer to enable freedom of choice.
    - 4.5.1.3 Secure background checks including the Adult Abuse Registry on all attendants, including relatives and backup attendants
  - 4.5.2 Provide technical assistance to consumers about the employment process including, but not limited to:
    - 4.5.2.1 Assisting consumer in the purchasing of Workers Compensation insurance policies
    - 4.5.2.2 Securing and maintaining a checking account to be used for payroll related items

- 4.5.2.3 Filing and maintenance of payroll records required for payroll and tax preparation, as related to attendant employees
- 4.5.2.4 Discussing appropriate employee/employer relationships, including those cases where the employee is also a relative
- 4.5.3 The provider agency is obligated to meet the following monitoring requirements:
  - 4.5.3.1 Monitor units used by consumers on a monthly basis; ensuring attendants do not exceed the number of units authorized by DSAAPD staff, including an appropriate use of flexed hours;
  - 4.5.3.2 Monitor time sheets to ensure they are submitted in a timely fashion and accurately reflect the hours and duties worked by the attendant;
  - 4.5.3.3 Conduct reviews on at least quarterly basis for the health, safety, and welfare status of the individual consumer and submit quarterly progress reports to the individual DSAAPD case manager;
  - 4.5.3.4 Conduct face-to-face visits with the consumer at least annually but more often as the consumer's needs indicate;
  - 4.5.3.5 Review and update the ISP during the annual face-to-face visit;
  - 4.5.3.6 Mail an annual satisfaction survey to consumers and supply DSAAPD with the results, including all comments as written in the surveys.
  - 4.5.3.7 Monitor that duties outlined in the ISP are in compliance with Child Labor Laws and related rules and policies, whenever applicable;
  - 4.5.3.8 The agency is obligated to the following additional requirements when consumers elect to use family members as paid service providers:
    - 4.5.3.8.1 When the paid service provider is a family member, conduct face-to-face visits with the consumer on at least a semi-annual basis.
- 4.5.4 The provider agency is obligated to meet the following administrative requirements:
  - 4.5.4.1 The provider agency must establish contact within five (5) working days of referral from DSAAPD
  - 4.5.4.2 The provider agency must perform the initial home visit within five (5) working days of establishing contact.
    - 4.5.4.2.1 If a home visit cannot be conducted within five (5) working days, the

DSAAPD CSP Case Manager must be notified

- 4.5.4.3 The provider agency must notify the DSAAPD CSP Case Manager, and the consumer in writing, within ten (10) working days of the home visit, when the provider is unable to serve the consumer. The written notice shall include the reason the provider is unable to serve the consumer.
- 4.5.4.4 If the consumer fails to establish service within 45 working days of the referral, DSAAPD will be notified. DSAAPD will then assess the reason for lack of initiation of service which may be followed by notice of intent to terminate eligibility.
- 4.5.4.5 The provider agency must establish the capability to respond to priority care emergencies. For this purpose, the use of subcontractors for emergency care is permitted.
  - 4.5.4.5.1 The provider agency is not required to obtain background checks on attendants used for emergency backup
  - 4.5.4.5.2 Emergency backup is defined as service provided for one week or less, when neither the regular attendant or backup attendant is available
- 4.5.4.6 For each consumer, the provider agency shall establish and maintain a case file, which includes the following:
  - 4.5.4.6.1 The Service Referral Form from DSAAPD;
  - 4.5.4.6.2 The ISP signed by the consumer and the provider agency;
  - 4.5.4.6.3 Documentation of the consumer and attendant(s) training activities;
  - 4.5.4.6.4 Documentation of any problems or concerns raised by the consumer, attendant(s) or other third party; the attempts to investigate the problem or concern; and disposition of the problem;
  - 4.5.4.6.5 Documentation of the annual reassessments of the ISP; and
  - 4.5.4.6.6 Documentation of all in-home visits and telephone contacts;
  - 4.5.4.6.7 Signed documentation that the provider has discussed appropriate

- employees/employer relationships and behaviors with the consumer
- 4.5.4.7 The provider agency will make a reasonable effort to confer with DSAAPD to resolve problems that threaten the continuity of the consumer's attendant services.
- 4.5.4.8 The provider agency may request permission of DSAAPD to reduce or terminate service when in the agency's professional judgment, one of the following occurs:
- 4.5.4.8.1 The consumer no longer needs the service or level of service currently being provided;
  - 4.5.4.8.2 The consumer needs a level of service that is beyond the scope and purpose of the attendant service program;
  - 4.5.4.8.3 The consumer's uncooperative behavior, abuse, misuse of the service or program;
  - 4.5.4.8.4 The unsafe and/or unsanitary conditions or activities in the consumer's place of residence, even though services are provided and listed on the ISP, jeopardizes the safety or health of attendant(s) and/or the provider agency's staff;
  - 4.5.4.8.5 The involvement of the consumer in illegal activities;
  - 4.5.4.8.6 The consumer submits timesheets for services not provided or for hours not worked by an attendant(s) or otherwise tries to defraud the program;
  - 4.5.4.8.7 The consumer does not pay the co-pay in accordance with the payment schedule mutually agreed upon by the consumer, agency and DSAAPD.
  - 4.5.4.8.8 The consumer fails to cooperate with the provider in filing the appropriate tax forms (Schedule H).
- 4.5.4.9 The provider agency must ensure access to authorized representatives of Delaware Health and Social Services to the participant's case files and medical records.
- 4.5.4.10 The provider agency must maintain the consumer's right of privacy and confidentiality

- 4.5.4.11 The provider agency must comply with DSAAPD quality assurance initiatives related to this program
  - 4.5.4.12 The provider agency must establish policies and procedures related to the resolution of consumer complaints and grievances.
  - 4.5.4.13 The provider agency must include a written procedure of how unresolved complaints or grievances will be communicated to DSAAPD.
- 4.6 Consumer responsibilities:**
- 4.6.1 Be responsible for all employment functions of the attendant including, but not limited to:
    - 4.6.1.1 Conduct hiring interviews for attendants.
    - 4.6.1.2 Supervise and direct attendant in job functions
    - 4.6.1.3 Secure and maintain a checking account to be used for payroll related items
    - 4.6.1.4 Maintain acceptable documentation for payroll and tax filing
    - 4.6.1.5 Complete payroll related tax preparation and filings in a timely manner
  - 4.6.2 Consumer may accept or reject attendants referred to them by a provider agency
    - 4.6.2.1 In the event the provider is unable to supply attendant(s) that are acceptable to a consumer, the consumer may be offered technical assistance to assess the consumer's rationale for rejecting all attendant(s) and/or be referred to another provider agency.
    - 4.6.2.2 Consumers are provided the option of hiring a relative or spouse as their paid attendant. A relative, including spouse is considered a paid employee and therefore the consumer is subject to the same requirements as employees referred by the agency. Individual withholding and tax filing for relatives employees must be performed in compliance with current Federal and State Payroll laws.
- 4.7 Allowable Activities**
- 4.7.1 Basic services performed by the attendant(s) include:
    - 4.7.1.1 Assistance with transferring to and from a bed, wheelchair, vehicle, or other environmental setting;
    - 4.7.1.2 Help with use of medical and non-medical equipment, devices, or assistive technology;
    - 4.7.1.3 Assistance with routine bodily functions, including:
      - 4.7.1.3.1 Health maintenance activities;

- 4.7.1.3.2 Bathing and personal hygiene;
- 4.7.1.3.3 Bowel or urinary evacuation;
- 4.7.1.3.4 Dressing and grooming; and
- 4.7.1.3.5 Food consumption, preparation and cleanup;
- 4.7.2 Ancillary services may also be provided, but only if the consumer is also receiving one of the above basic services. Ancillary services include:
  - 4.7.2.1 Homemaker-type services, including cleaning, laundry, shopping and seasonal chores;
  - 4.7.2.2 Companion-type services, including transportation, escort and facilitation of written, oral and electronic communication;
  - 4.7.2.3 Assistance with cognitive tasks, including bill payment and money management, planning activities and decision-making.
- 4.7.3 Attendants may accompany consumers on vacation or other temporary stays away from home. However, attendant service program funds will not be allowed to cover any of the costs associated with the travel for the consumer or the attendant(s). The roles and responsibilities of the attendant(s) and the consumer are the same as when at home.
- 4.8 Prohibited Activities:
  - 4.8.1 PAS may not be provided in a long term care facility, acute care facility, or group home except:
    - 4.8.1.1 With prior authorization from DSAAPD Case Manager, PAS may be provided in an acute care setting for no longer than 10 calendar days.
- 4.9 Employees must be age 18 or above
  - 4.9.1 The hiring of a minor may be considered on a case-by-case basis and prior approval by DSAAPD is required.
    - 4.9.1.1 The employment of a minor employee is subject to Child Labor Laws and related rules and policies.
    - 4.9.1.2 Care must be exercised if service is provided by a minor, as they are limited to hours and times they are permitted to work, as outlined in Child Labor Laws and related rules and policies.
- 4.10 Consumers and the provider agency shall share in the responsibility for obtaining attendants when service hours become difficult to fill.
- 4.11 The use of flexed hours within the same pay period is permitted. No hours can be "borrowed" or "advanced" in anticipation of paying them back through flexing at a later date.

- 4.12 Additional short term attendant service hours may be authorized for consumers if determined eligible by the DSAAPD Case Manager, and if funding permits.

#### 6.0 INVOICING REQUIREMENTS

- 6.1 The providers will invoice DSAAPD pursuant to the DSAAPD Policy Manual for Contracts
- 6.2 The following information will also be included on the invoices:
  - 6.2.1 Consumer name
  - 6.2.2 Authorized Hours
  - 6.2.3 Hours utilized
  - 6.2.4 Monthly Worker's Compensation billed
  - 6.2.5 Monthly Criminal Background checks billed

Dr. Ora Spamm  
Director  
Programs for Exceptional  
Children  
South Carolina State Department  
of Education  
1429 Senate Street, Room 505  
Columbia, SC 29210

**Digest of Inquiry**  
(May 13, 1993)

- Is it appropriate for a public agency to bill the costs of special education services to Medicaid or any other third party insurer?
- Before engaging in third party billing for special education services, must a public agency seek parental permission and inform parents of all of their rights in the process?

Digest of Response  
(September 10, 1993)

*Insurance Billing Must be Voluntary if Threat of Financial Loss Exists*

Public agencies may access parent's insurance, including Medicaid, to pay for necessary special education services in circumstances where the parents would incur no realistic threat of a financial loss. However, if a realistic threat of financial loss would occur from third party billing, use of parental insurance proceeds to pay for special education services must be voluntary.

*Insurance Billing Requires Parental Consent*

Public agencies must obtain parental consent to file an insurance claim for special education services and must inform parents of any potential financial losses that they could incur. However, public agencies may not condition provision of necessary special education services on parental consent to filing of an insurance claim, and parents may refuse to sign a consent form without jeopardizing their child's receipt of services.

Text of Inquiry

South Carolina is in the process of implementing a program to provide reimbursement through Medicaid for certain health-related services provided by school districts for children with disabilities. Representatives of the pilot projects are requesting guidance regarding appropriate procedures for dealing with third party insurance.

It is our understanding that Medicaid is the payor of last resort, which means, of course, that Medicaid will not provide reimbursement for expenses that a third party, such as a private insurance company, is legally obligated to pay. School districts are being told by the South Carolina Health and Human Services Finance Commission (the designated state agency responsible for the Medicaid program) that they should attempt to obtain voluntary permission from the parents to bill for Medicaid-reimbursable services. Then, if the parents' insurance policy does not pay for the service, the school district can bill Medicaid.

We are concerned that school districts may encounter future problems if they bill for third party insurance, even if they have prior approval from the parents. Since all services to children with disabilities are mandated to be provided at no cost to the parents, the concern is that a lawsuit could be filed by the parents a number of years later stating that they did not truly realize the long-term implications of permitting their insurance to pay for services to their children. We understand that, in accordance with the Interpretation of Part B of the Education of the Handicapped Act and Section 504 of the Rehabilitation Act (December 30, 1980), a school district may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of children with disabilities would suffer a financial loss.

We are seeking your advice regarding whether it is appropriate and ethical, in your opinion, for school district to bill for third party insurance. Then, in the event it is appropriate for school districts to bill for third party insurance, must they seek the permission of the parents in writing and inform them of all of their rights in the process (including the fact that there may be a potential loss of lifetime benefits). Your assistance in this matter will be very much appreciated. Thank you for your continuing help as we strive to provide appropriate programs for our state's children with disabilities.

Text of Response

I am writing in further response to your letter requesting information regarding the appropriateness of a school district's billing an insurer to pay for services covered under Part B of the Individuals with Disabilities Education Act (Part B). I apologize for the delay in responding.

Specifically, you asked two questions; first, is it appropriate for a school district to bill for third party insurance? Under Part B of the Individuals with Disabilities Education Act (Part B), each State and its local school districts are required to make a free appropriate public education (FAPE) available to children with specified disabilities within the State in mandated age ranges. 34 CFR §§ 300.121 and 300.8. FAPE includes, among other elements, special education and related services, provided at no cost to parents, in conformity with an individualized education program (IEP). In meeting their obligation to provide special education and related services without charge, public agencies "may use whatever State, local, Federal, and private sources of support are available in the State to meet the requirements of this part." 34 CFR § 300.301(a). This regulation also provides that "[n]othing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or pay for services provided to a child with a disability." 34 CFR § 300.301(b). In December of 1980, the Secretary of Education issued a Notice of Interpretation on Use of Parent's Insurance Proceeds which concluded that:

The requirements that a free appropriate public education be provided "without charge" or "without cost" mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of [children with disabilities] would suffer a financial loss not incurred by similarly situated parents of [nondisabled] children. Financial losses include, but are not limited to, the following:

- (1) A decrease in available lifetime coverage or any other benefit under an insurance policy;
- (2) An increase in premiums under an insurance policy; or
- (3) An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.

45 Fed. Reg. 86390 (Dec. 30, 1980) (copy enclosed).

Therefore, public agencies may access parent's insurance to pay for required special education and related services in

circumstances where the parents would incur no realistic threat of a financial loss. However, in circumstances where parents would incur a realistic threat of a financial loss, use of parent's insurance proceeds must be voluntary.

In your second question, you asked if the school district must "seek the permission of the parents and inform them of all their rights in the process (including the fact that there may be a potential loss of lifetime benefits)." Public agencies must obtain parental consent for the filing of an insurance claim, including informing parents of any potential financial losses they could incur. However, public agencies may not condition the provision of special education and related services on parental consent to the filing of an insurance claim. Therefore, parents may refuse to sign a consent form without jeopardizing receipt of services to their child.

I hope that the information in this letter is helpful. If this Office can be of further assistance, please let me know.

Patricia J. Guard  
Acting Director  
Office of Special Education Programs

**Brian J. Hartman**

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**From:** Hodges Kyle (DSHS) <kyle.hodges@state.de.us>  
**Sent:** Thursday, November 15, 2012 4:24 PM  
**To:** Brian J. Hartman  
**Subject:** FW: Draft of Revised PDN Policy  
**Attachments:** PDNNotesrevised11132012 doc.docx; PDN Revision Draft11142012.doc.docx

Brian – FYI.

Kyle

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**From:** Michalik Dave (DHSS)  
**Sent:** Thursday, November 15, 2012 9:28 AM  
**To:** Hodges Kyle (DSHS)  
**Cc:** Mahaney Rosanne (DHSS); Groff Stephen (DHSS); Shuhart Nicolette (DHSS); Summers Sharon (DHSS)  
**Subject:** RE: Draft of Revised PDN Policy

Kyle, it turns out that I fell behind on this but I appreciate your bringing it back to my attention. We actually had finished up most of our agency responses and accompanying changes to the PDN Provider Policy Manual, so I am attaching copies of both so you and the SCPD can share any further comments you may have. Once we finalize this step we will publish the results via the APA.

Thanks for your assistance. Let me know if any questions. -Dave

Dave Michalik  
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**From:** Hodges Kyle (DSHS)  
**Sent:** Friday, October 05, 2012 1:40 PM  
**To:** Michalik Dave (DHSS)  
**Cc:** Mahaney Rosanne (DHSS); Groff Stephen (DHSS); Shuhart Nicolette (DHSS)  
**Subject:** RE: Draft of Revised PDN Policy

Dave – do you know the status of the PDN regs? Don't know if I have missed something along the way. I have attached an email that we sent which included the attached comments. Thanks.

Kyle

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**From:** Michalik Dave (DHSS)  
**Sent:** Thursday, November 18, 2010 9:52 AM  
**To:** Hodges Kyle (DSHS)

**Cc:** Mahaney Rosanne (DHSS); Groff Stephen (DHSS); Shuhart Nicolette (DHSS)  
**Subject:** Draft of Revised PDN Policy

Hi, Kyle. My apologies for the delays in getting our revisions to the PDN policy to you. But it is attached and we look forward to your feedback.

Let me know if any questions. Thanks! -Dave

Dave Michalik  
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**§§ 1.0 and 5.1:**

Agency Response: The reference to MCO's is for informational purposes only. This policy relates to Medicaid clients who are exempt from managed care coverage. The scope of service, policies, procedures and processes in this provider specific manual is for fee-for-service PDN providers.

**§§1.0 and 1.1.1:**

Agency Response: The benchmark level remains as guidance for fee-for-service PDN providers. DMMA agrees with your suggestion, as written below:

1.1.1 Children under age 21 are eligible for up to sixteen hours of PDN daily, subject to the exceptions in 1.1.5 and 5.2.

**§§1.1.2 and 5.2.3 and 5.2.6:**

Agency Response: Your suggestion that DMMA adopted above fulfills items A and B.

Agency Response: In response to item C., DMMA will add the following new subsection at 1.1.3.3 to the proposed policy:

1.1.3.3 DMMA considers sleep for the caregiver to be covered under the 16 hours of PDN:

Agency Response: In response to item D, DMMA appreciates your suggestion to revise §5.2.6, however, no change to the policy was made as a result of this comment. The approved PDN benefit is not lost and thus medical care is not compromised,

Agency Response: Regarding your recommendation to amend §1.1.2, DMMA agrees, as written below:

1.1.2 Adult Medicaid clients age 21 and over are eligible for up to eight hours of PDN daily, subject to the exceptions in 1.1.3, 1.1.5, and 1.1.6.

**§1.1.3.2:**

Agency Response: Based on feedback from the DMMA Medical Director and staff nurses with PDN clinical experience, we will retain the criteria at 1.1.3.2 without modification to the policy.

**§1.1.5:**

Agency Response: DMMA agrees. §1.1.5 is amended by substituting "treating" for "admitting".

**§5.1.4:**

Agency Response: PDN approved hours are inclusive of occasional variation in hours which may occur in extenuating circumstances. No change to the policy was made as a result of this comment.

**§5.2.1:**

Agency Response: DMMA will add the word "for" between "responsibility" and "the" in the second sentence. DMMA agrees to replace the word "capable" with "physically and mentally able".

**§5.2.4**

Agency Response: DMMA is not authorizing school-related PDN, but rather is authorizing PDN when a child needs the services in the home, hospital, or nursing facility, and will also cover the PDN in the

child's other natural settings or environments including a school location. No changes are made as a result of this comment.

**§5.2.5:**

Agency Response: DMAP Agrees. While it remains the responsibility of the parent/caregiver to accompany the child during transport, PDN services can be provided when the parent is unable to assist because of employment, school, or physical or mental incapacity. DMMA will add "physical or mental incapacity" to the exceptions in 5.2.5.

# Private Duty Nursing Program Provider Specific Policy

## 1.0 Overview

The purpose of the Private Duty Nursing Program is to provide skilled nursing care to DMAP recipients who require care that can only be provided by a licensed Registered Nurse (RN), Licensed Practical Nurse (LPN), or Certified Registered Nurse Practitioner (CRNP). Effective July 1, 2007, Private Duty Nursing (PDN) services are provided to the majority of Medicaid clients through a Managed Care Organization (MCO). MCO's are required to provide, at a minimum, coverage of services as described in this Policy. Services provided to clients enrolled in a MCO plan are not billed to DMAP. The provider shall provide services only under arrangement with the MCO.

PDN services are provided to Medicaid clients in their home or other DMAP approved community setting as an alternative to more expensive institutional care. Generally, the total cost of PDN services shall not exceed the cost of care provided in an institutional setting.

All PDN services must be prior authorized. The Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary** to treat or ameliorate a medical condition. **EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR AUTHORIZATION.** Providers shall refer to the Managed Care section of the General Policy for the required forms and procedures related to Diamond State Partners (DSP).

## 1.1 Service Limitations

1.1.1 Children under age 21 are eligible for up to sixteen hours of PDN daily, subject to the exceptions in 1.1.5 and 5.2..

1.1.2 Adult Medicaid clients age 21 years and over are eligible for up to eight hours of PDN daily, subject to the exceptions in 1.1.3 and 1.1.5.

1.1.3 Adult Medicaid clients that are technology dependent are eligible for up to 16 hours of medically necessary PDN daily. Technology dependent adults must:

1.1.3.1 Require mechanical ventilation or mechanical ventilation via tracheostomy, or

1.1.3.2 Have a complex tracheostomy that meets all of the following criteria;

- Have a tracheostomy with the potential for decannulating or documentation of attempts to decannulate with subsequent inability to decannulate;
- Require routine nebulizer treatments followed by chest PT (Physiotherapy) at least 4 times per day or nebulizer treatments at least 4 times a day, provided by a Licensed Nurse or Licensed Respiratory Therapist;
- Require respiratory assessment and documentation every shift by a Licensed Respiratory Therapist or Trained Nurse;

- Have a Physician's order for oxygen therapy with documented usage;
- Require tracheostomy care at least daily;
- Have a Physician's order for tracheal suctioning as needed; AND be deemed to be at risk to require subsequent mechanical ventilation.

1.1.3.3 DMMA considers sleep for the caregiver to be covered under the 16 hours of PDN.

1.1.4 DMMA may approve 24 hour PDN for a limited period (3-4 days) to ensure a successful transition to a non-institutional setting. PDN hours will be subsequently reduced in a graduated fashion until the daily maximum is attained.

1.1.5 An increase in hours may be approved if additional hours will avoid hospitalization or institutional placement as a cost effective measure. This will depend on the medical necessity, the amount of additional hours needed and the letter of medical necessity from the admitting physician.

1.1.6 DMMA may approve additional PDN hours based on compelling justification at the discretion of and with written approval by the Medicaid Director.

1.1.7 PDN services must be provided in a non-institutional setting.

1.1.8 Arrangements for multiple clients may be considered if such arrangements are medically appropriate and advantageous to both the client and to DMAP. The nurse-client ratio will not exceed 3 clients per nurse unless authorized by the Medical Review Team.

## **2.0 Qualified Providers**

2.1 Private duty nursing may be provided by any registered nurse (RN), licensed practical nurse (LPN) or certified registered nurse practitioner (CRNP) who has a professional license from the State to provide nursing services.

2.2 Home health agencies that employ and provide qualified nursing staff as described above or self-employed qualified nursing staff are considered qualified providers and may enroll as PDN providers.

## **3.0 Provider Requirements**

3.1 The maximum number of hours provided by an individual nurse will be restricted to a level that can safely and reasonably be provided. No individual nurse will be authorized to work more than a 16 hour shift in a 24-hour period except in an emergency situation which will be reviewed then approved or denied by the Medical Review Team.

3.2 The private duty nursing provider is required to keep the following documentation in the patient's record:

- Documentation of orientation to client's care needs and demonstration of nursing skills necessary to deliver prescribed care.

- A written plan of care that is established, signed, and dated by the attending practitioner which includes orders for medications, treatments, nutritional requirements, activities permitted, special equipment and other ordered therapies.
- Orders renewed, signed and dated at least once every 60 days or sooner as the severity of the client's conditions requires.
- Documentation that the nurse promptly alerts the practitioner to any changes that suggest a need to alter the plan of care.
- Signature log with dates, duration of visits, types of service, and signature of the RN/LPN

## 4.0 Reimbursement

4.1 Private duty nursing services provided to eligible DMAP clients are reimbursed using prospectively determined rates. The unit of service for agency providers is one hour, and for self-employed nurses is 15 minutes. A weekly maximum limit is established for each client by the DMAP based on the authorized services.

4.2 Rates for agency services are reviewed annually. The Medicaid rate will relate to the lowest prevailing usual and customary charge, as determined by a survey of all private duty nursing service agencies. Agencies will be reimbursed the lower of their usual and customary charges or the maximum allowable rate.

4.3 Rates for self-employed nurses will be individually negotiated, but will not exceed a predetermined percentage of the weighted average agency rate. Rates may not be renegotiated more than once annually except in extenuating circumstances. Increases will be limited to the normal medical inflation used by DMAP. Self-employed nurses will be reimbursed the lower of their usual and customary charges or the maximum allowable rate.

4.4 Providers are not required to submit cost reports to the DMAP. There are no retrospective settlements on claims paid.

4.5 The baseline PDN reimbursement rate will normally represent services provided by one nurse to one client. An adjusted reimbursement rate per client will be established for medically appropriate PDN services provided by a single nurse for up to three clients. Maximum rates are established according to the following table:

One client:	Rate for One =	100% of established baseline rate
Two clients:	Rate for Each =	71.5% of baseline rate
Three clients:	Rate for Each =	70.62% of baseline rate

4.6 Counting of 15-minute increments: Self-employed nurse visits are to be rounded to the nearest 15-minute increment. The following chart is to be used when determining the number of units to be billed.

1 Unit	1 minute to <23 minutes
2 Units	23 minutes to <38 minutes
3 Units	38 minutes to <53 minutes
4 Units	53 minutes to <68 minutes
5 Units	68 minutes to <83 minutes

6 Units	83 minutes to <98 minutes
7 Units	98 minutes to <113 minutes
8 Units	113 minutes to <128 minutes

## 5.0 Prior Authorization

### 5.1 General Requirements

5.1.1 Private duty nursing services must be prior authorized before the services are rendered.

5.1.1.1 Private duty nursing services for clients who are eligible for the Elderly and Disabled HCBS Waiver program (which now incorporates the former Assisted Living Medicaid Waiver program and the former Acquired Brain Injury Medicaid Waiver), must be prior authorized by the nursing staff of the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). See the Index in back of General Policy for the appropriate address and telephone number.

5.1.1.2 All other requests for prior authorization should be directed to the appropriate Medicaid Unit. (see Index section 20.0 in General Policy for the address and telephone number of each Medicaid Unit, <http://www.dmap.state.de.us/downloads/manuals/General.Policy.Manual.pdf>).

5.1.2 Initially, a DMMA Medical Services Nurse completes a medical assessment. The client will receive a written notice of approval or non-approval for PDN services.

5.1.3 The on-going need for PDN care is routinely/periodically re-evaluated. DMMA may determine that PDN hours may be reduced or increased due to the stability of the patient, caregiver work schedule and other factors.

5.1.4 PDN hours must be used for the period of time in which they are authorized. If the hours authorized are not used on a particular day, the hours do not carry over to the next day or weekend nor can the hours be "banked" to be used at a later time.

### 5.2 Requirements for Children

5.2.1 PDN will only be authorized when there is at least one caregiver willing and able to accept responsibility for the client's care when the nurse is not available. DMMA expects that parents/caregivers be willing and physically and mentally able to accept responsibility the child's care. If the parent/caregiver cannot or will not accept responsibility for the child's care when PDN is not authorized or available, the client is deemed not to be in a safe environment and PDN will not be authorized.

5.2.2 PDN is adjusted to cover work and travel time of the parent/caregiver or to cover education (class schedule) and travel time of the parent, if there is not another parent/caregiver in the home. PDN is authorized for up to 40 hours per week plus an additional five hours for travel to and from work or school. Parent/guardian work hours/schedule must be verified every

six months. PDN for education is for employment related classes; vo-tech, GED, high school, college, etc. and must be documented and verified every six months.

5.2.3 During those hours when a parent/caregiver needs to sleep, and a high risk or technology dependent child continues to require skilled care, PDN services may be approved for a maximum of 8 additional hours. Generally, these hours will fall between 10pm and 8am.

5.2.4 PDN may be approved to accompany school-age children that are technology dependent or have other DMAP approved high risk conditions during the transport to and from school and to provide medically necessary care during school hours when PDN services are also required outside of school hours.

5.2.5 DMMA reimburses for medically necessary transportation through a Medicaid transportation broker. DMMA expects the parent/caregiver to accompany the client in transport. If, because of employment or school, or physical or mental incapacity the parent/caregiver cannot accompany the client, the prior authorized PDN may accompany the client. If the client is transported to a medical appointment or the hospital with the PDN, then upon the arrival of the parent/caregiver, the PDN service is no longer required. PDN will not be authorized for a nurse to accompany a client to a medical appointment or hospital stay when the parent/caregiver is available.

5.2.6 DMMA may approve PDN when a child is home sick with a cold, virus, or normal childhood illness, or there are unplanned school closures or inclement weather days. However, additional hours must be prior authorized. Home health agencies may not be able to provide "on demand or same day service." Families should contact DMMA as soon as they know about an unplanned school closure, etc. and find a willing and available provider.

5.2.7 DMMA may approve PDN to cover summer vacation as well as scheduled school year holiday vacations for school age children if the parent/caregiver requests coverage on a timely basis. Absence of parents/guardian from the home for employment or work-related education reasons must be documented.

Section 6.0 Reserved

7.0 remains as is.