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DISABILITIES LAW PROGRAM

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MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Legislative and Regulatory Initiatives

Date: March 4, 2014

I am providing my analysis of thirteen (13) legislative and regulatory initiatives in anticipation of the March 12, 2014 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. DOE Final Charter Schools Regulation [17 DE Reg. 913 (3/1/14)]

The SCPD and GACEC commented on the proposed version of this regulation in December, 2013. A copy of the December 18, 2013 GACEC letter is attached for facilitated reference. The Department of Education has now adopted a final regulation with one (1) amendment prompted by the commentary.

First, the Councils noted that State legislation requires the Department to "establish eligibility requirements for applicants desiring to apply for funding" and "criterion to evaluate applications for funding". The Councils surmised that the DOE intended to adopt standards at a sub-regulatory level since the standards were absent from the proposed regulation. The DOE responded that the standards will be posted on the DOE website.

Second, the Councils recommended that the definition of "high-need students" be amended to include students with disabilities. The Department modified the definition to include a reference to students with disabilities and English language learners:

> "**High Need Students**" mean students that qualify as low economic status pursuant to Department determination [, **to include Students with Disabilities and English Language Learners**].

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DELAWARE'S PROTECTION AND ADVOCACY SYSTEM FOR PERSONS WITH DISABILITIES

The above amendment is "oddly" worded and could be interpreted to only include students with disabilities and English language learners who meet "low economic status" standards. If that is the Department's intent, the amendment is entirely "fluff" and "surplusage" since it does not expand the scope of the definition, i.e., "high needs students" are only those that meet "low economic status" standards. Since the DOE's commentary describes an intent to "expand" the definition to include students with disabilities and English language learners (p. 913), I suspect the Department intended to establish three (3) independent categories of "high needs students" - 1) low economic status; 2) students with disabilities; and 3) English language learners.

The Councils may wish to alert the DOE that its amendment may not implement its intention. Alternatively, the Register version of the amendment may not conform to the version the DOE submitted. A courtesy copy of the inquiry could be shared with Rep. Heffernan and Rep. Baumbach who were the prime sponsors of amendments to H.B. No. 165 promoting inclusion of students with disabilities within the scope of "high need students".

2. DOE Final Paraeducator Permit Regulation [17 DE Reg. 919 (3/1/14)]

The SCPD and GACEC commented on the proposed version of this regulation in January, 2014. A copy of the January 16, 2014 GACEC letter is attached for facilitated reference. The Department of Education has now adopted a final regulation incorporating several revisions suggested by the Councils.

First, the Councils identified grammatical errors in §§3.1.1.4 and 3.1.2.4. The Department corrected the errors.

Second, the Councils recommended substitution of "and" for "or" in §3.2.1. The change was made.

Third, the Councils identified a grammatical error in §4.2. The error was corrected.

Fourth, the Councils identified a grammatical error in §5.2. The error was corrected.

Since the regulation is final, and the Department addressed each identified concern, I recommend no further action.

3. DOE Final Curricula Alignment with State Content Standards Reg. [17 DE Reg. 915 (3/1/14)]

The SCPD and GACEC commented on the proposed version of this regulation in January, 2014. A copy of the January 16, 2014 GACEC letter is attached for facilitated reference. The Department of Education has now adopted a final regulation incorporating two (2) amendments prompted by the commentary.

First, the Councils endorsed a provision covering special populations, including students with disabilities. The DOE acknowledged the endorsement.

Second, the Councils recommended correction of a grammatical error in §2.0, definition of "Evidence". The DOE corrected the reference.

Third, the Councils suggested that the DOE consider whether the standards were too general and diluted. The DOE made one (1) change to §4.2 to delete a reference which literally limited DOE review to site monitoring visits.

Since the regulation is final, and the DOE addressed the Councils' concerns, I recommend no further action.

4. DFS Final Child Placing Agencies Regulation [17 DE Reg. 925 (3/1/14)]

The SCPD and GACEC commented on earlier versions of this regulation in July, 2013. The commentary resulted in issuance of a revised proposed regulation in December, 2013. The SCPD and GACEC submitted an extensive set of comments on the December initiative. A copy of the SCPD's December 23, 2013 memo is attached for facilitated reference. The Division of Family Services has now adopted a final regulation incorporating some changes prompted by the commentary. The Division lists the changes at pp. 925-926.

First, the SCPD (p. 7) recommended adoption of a revised definition of "complaint investigation" in §5.0. DFS amended the reference.

Second, the SCPD (p. 7) recommended adoption of a revised definition of "guardian". DFS amended the definition "per advice from the Deputy Attorney General".

Third, the SCPD (p. 2, Par. 6) recommended that notice be provided to affected individuals (e.g. foster and adoptive parents; foster children) if a licensee or applicant requests a variance or waiver of standards per §16.0. Such notice would facilitate submission of comments by affected parties to the Division. The Division decided to maintain the current protocol which does not require notice. It modified a related provision so interested parties could obtain a copy of the DFS document approving the variance/waiver. Obviously, it's too late to provide input on a request for a variance/waiver after it's been granted.

Fourth, the SCPD (pp. 2-3, Par. 7) recommended some amendments to §18.0 to expand anti-retaliation protections for persons reporting incidents to DFS or cooperating with an investigation. DFS adopted revisions "upon advice from the Deputy Attorney General". "Volunteers" are now covered per the SCPD's recommendation. Protection is also extended to persons cooperating with an investigation per the SCPD's recommendation.

Fifth, the SCPD (p. 3, Par. 9) recommended expansion of the scope of "reportable incidents". DFS amended §19.0 to include attempted suicide per the SCPD's suggestion.

Sixth, the SCPD (p. 3, Par. 10) recommended lowering of the maximum air temperature from 85 degrees at floor level. DFS revised the standards in §§19.2.6 and 101.10 to 82 degrees at 3 feet above floor level per national guidelines. It also changed the minimum temperature standard from 65 degrees to 68 degrees based on national guidelines.

Seventh, the SCPD (p. 4, Par. 11) recommended reconsideration of a bar on employment "in any capacity" of "any person convicted of ...offenses against a child". The SCPD also objected to bars on employment based on arrests and indictments without conviction per EEOC guidance. Based on advice from its Deputy Attorney General, DFS adopted several amendments to §§42.5-42.9.

Eighth, the SCPD (p. 5, Par. 14) suggested adding a reference to exploitation of a child to §44.0. DFS added a reference to a different section.

Ninth, the SCPD (p. 7) recommended substitution of "incident" for "incidence" in §44.5.1. The substitution was made.

Tenth, the SCPD (p. 5, Par. 16) recommended listing additional conduct (e.g. throwing child; hitting with closed fist) barred by Title 11 Del.C. §468(1)c. DFS added several examples of barred conduct to §77.1.6.

Eleventh, the SCPD (p. 5, Par. 16) recommended that DFS not delete specific references to barred conduct (e.g. shaking; hair pulling). The references were reinstated in §77.1.6 .

Twelfth, the SCPD (pp. 5-6, Par. 20) recommended that DFS add a bar on mechanical restraint and other forms of restraint. DFS added a ban on mechanical restraint and other forms of restraint to §77.1.7.

Thirteenth, the SCPD (p. 6, Par. 23) recommended inserting references to prevention activities and Selective Service registration. A reference to Selective Service registration was added to §85.4.7.

Fourteenth, the SCPD (p. 6, Par. 24) objected to a broad bar on persons serving as a foster parent because of past removal of a child for abuse or neglect without regard to passage of time or rehabilitation. The language in §89.0 was revised.

Fifteenth, the SCPD (p. 6, Par. 25) objected to a categorical ban on anyone over sixty-five years of age becoming a foster parent. DSAAPD submitted a conforming set of comments. See attached January 8, 2014 memo from William Love, Director. DFS deleted the age restriction from §95.1.

Sixteenth, the SCPD (p. 7, Par. 26) recommended that DFS embellish its standards on pets and animals. DFS expanded §§111.1 and 111.2 to cover aggressive animals and those which could transmit diseases to humans.

Since the regulation is final, and DFS adopted many revisions prompted by the commentary, I recommend sending a "thank you" communication. The Councils may also wish to notify DSAAPD and AARP that DFS deleted the age limit on serving as a foster parent.

5. DMMA Proposed Preventive Services Regulation [17 DE Reg. 885 (3/1/14)]

As background, Section 4106 of the Affordable Care Act authorizes states to adopt a Medicaid State Plan amendment in the context of preventive services. In a nutshell, a State can secure an additional 1% federal Medicaid match for specified preventive services if it agrees to cover the following: preventive services assigned a grade of A or B by the U.S. Preventive Services Task Force (USPSTF) and approved vaccines and their administration recommended by the Advisory Committee on Immunization Practices (ACIP). CMS guidance is contained in the attached State Medicaid Director Letter, SMD#13-002 (February 1, 2013) and Q.&A document.

Delaware DMMA proposes to adopt a State Plan amendment to qualify for the additional match effective April 1, 2014. The actual amendment is brief and appears to conform to the CMS guidance. At 887.

Since the regulation will result in confirmation of Delaware Medicaid coverage of specified preventive services and increase federal funding, I recommend endorsement.

6. DMMA Prop. Adult Group Medicaid Claiming Methodology Reg. [17 DE Reg. 887 (3/1/14)]

The Division of Medicaid & Medical Assistance proposes to adopt a Medicaid State Plan amendment effective January 1, 2014. It previously advertised the initiative in the December 19, 2013 issues of the News Journal and Delaware State News. At 889.

As background, the Affordable Care Act (ACA) contemplates State Medicaid programs covering individuals with countable income up to 133 percent of the poverty level. Delaware Medicaid already covered this population and Delaware therefore qualifies as an "expansion state'. At 888 and 892. In order to qualify for an enhanced federal Medicaid match for covering this group of individuals, the State must adopt a Medicaid Plan amendment based on a CMS template. The federal Medicaid match for expansion states is described at the top of p. 889. DMMA envisions the receipt of the following federal funds based on the initiative: $78,254,636 in FFY 14 and $137,495,659 in FFY15. At 890.

Since the Plan amendment is designed to achieve conformity with CMS guidance under the ACA, I recommend endorsement.

7. DMMA Prop. Medicaid Prescription Drug Reimbursement Reg. [17 DE Reg. 893 (3/1/14)]

As background, the Division of Medicaid & Medical Assistance notes that federal law requires Medicaid agencies to reimburse pharmacies for outpatient drugs based on two (2) components: 1) drug ingredient/acquisition cost; and 2) dispensing cost. The first component has historically been based on an "Average Wholesale Price" (AWP) benchmark. However, the federal Office of Inspector General determined that the AWP was flawed and resulted in excess payments to pharmacies. CMS has now contracted with a CPA firm to develop a new "National Average Drug Acquisition Cost" (NADAC) pricing benchmark. Any state wishing to adopt the NADAC must submit a Medicaid State Plan amendment to CMS.

Delaware DMMA proposes to adopt a Plan amendment incorporating the NADAC measure of acquisition cost. At the same time, it is increasing its reimbursement for dispensing cost from $3.65 to $10.00 per prescription. DMMA projects the following savings to State General Funds based on the new reimbursement standards: $604,000 (October 1, 2014-September 30, 2015); $1,340,000 (October 1, 2015 - September 30, 2016). Since the payment for dispensing a prescription is almost tripling (increasing from $3.65 to $10.00), these cost savings could only occur if the NADAC benchmark is much lower than the AWP benchmark.

In the past, Delaware pharmacies have balked at the low Medicaid reimbursement rates and threatened to not fill prescriptions funded by Medicaid. The Councils lack sufficient information to assess whether the new pharmacy reimbursement standards are adequate. The effective date of the Plan amendment is April 1, 2014. At 895. Therefore, DMMA envisions adopting the new methodology without time to even consider comments which can be submitted until March 31. I recommend commenting that the Council(s) have reviewed the proposed regulation and have noted that pharmacies have balked at low drug reimbursement rates in the past. See attached 8 DE Reg. 961-962 (February 1, 2003). Cf. attached "How Medicaid Is Squeezing Specialty Pharmacy Profits" (February 18, 2014). The Councils could then note that they are unable to adopt a position on the proposed regulation given lack of information on whether the rates fairly compensate pharmacies.

8. DMMA Prop. Pathways to Emp. Medicaid Plan Amendment Reg. [17 DE Reg. 930 (3/1/14)]

The SCPD and GACEC commented on this initiative originally published in the January, 2014 Register of Regulations. A copy of the January 30, 2014 SCPD memo is attached for facilitated reference. However, since a concept paper and draft Plan amendment were not included in a DMMA link until January 17, the Division of Medicaid & Medical Assistance is extending the opportunity to comment until March 31, 2014.

Since the only document which I lacked when compiling my analysis of the regulation in January was the 55-page Plan amendment, I am providing a supplemental analysis focusing on that document.

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

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

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

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

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

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

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

p. 7: The standard defining the credentials of persons conducting reevaluations is rather meager:

For all target groups, reevaluations are conducted by individuals holding an associates degree or higher in a behavioral, social sciences, or a related field OR experience in health or human services support which includes interviewing individuals and assessing personal, health, employment, social or financial needs in accordance with program requirements.

This standard is reiterated at pp. 11-12 and 15. An Employment Navigator preparing a plan of care does not even need a high school diploma. A telephone receptionist for a non-profit or public agency will generally meet the standard of "experience in health or human services support which includes interviewing individuals and assessing ...needs in accordance with program requirements." Moreover, an individual with only geriatric experience would qualify under the above standard despite no familiarity with services for teens and young adults. This represents a major weakness in the proposal, especially for low-incidence populations (e.g. TBI) who have very specialized needs.

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

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

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

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

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

p. 26: The standards for financial coaches appear to be very generic, i.e., persons with some financial planning experience may serve as financial coaches despite little experience with disability-based planning. I suspect that few financial planners are familiar with Miller Trusts, the Delaware CarePlan Trust, the Social Security PASS program, housing assistance programs, and the Social Security Administration's Ticket to Work Program. Perhaps this level of sophistication with disability-related financial planning is achieved through the training identified on p. 27. If that training does not address programs such as the Delaware CarePlan Trust, PASS program, and Ticket to Work, this section should be revised to require background at least equivalent to DVR's benefits planners.

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

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

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

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

I recommend sharing the above observations with DMMA and partner agencies as a supplement, and not in lieu of, the SCPD's January 30 commentary.

9. DSS Prop. TANF Employment & Training Program Sanction Reg. [17 DE Reg. 897 (3/1/14)]

The Division of Social Services proposes to adopt revised TANF Employment & Training Program standards which primarily focus on sanctions.

As background, families participating in the program are generally subject to sanctions if they do not comply with work activity requirements. The current sanction protocol requires the TANF case to be closed, followed by 4 consecutive weeks of participation in work activities to justify reopening, and closure of the case for at least 1 month. At 898. DSS proposes to revamp this approach based on the following rationale:

> When examining TANF work participation rates it was discovered that many families begin to immediately re-participate and that the mandatory one month closure was a significant hardship since they were incurring expenses as a result of participating. Additionally, these families while participating were not reflected in the TANF work participation rate because they were not receiving a grant.
>
> The policy change would remove the requirement that the case be closed for at least one (1) month and reopen the TANF case at the beginning of the four (4) week participation period.
>
> This change allows families to immediately reengage and potentially not see a reduction in their TANF grant, while also raising the TANF work participation rate by an estimate three (3) percent.
>
> Approximately, thirty-two (32) more families a month will receive TANF benefits because of the rule change.

At 898.

I recommend endorsement since the primary change in standards promotes employment activities and program participation. However, I have two (2) observations.

First, a single custodial parent of a child under age 6 may qualify for an exemption from a sanction if child care is not available. Unavailability based on lack of a proximate day care option is based on the following standard (§3011.2., Par. 1.2a):

> Appropriate child care is unavailable within a reasonable distance from their home or work. Reasonable distance is defined as care that is located in proximity to either a parent's place of employment or the parent's home; generally care that is within a one hour drive from either home or work.

I recommend that DSS reconsider the "one hour drive" standard. For example, if a single parent lived and worked in Wilmington, and child care were only available in Dover, that would be presumptively a "reasonable distance". This means the parent would have to drive 45 miles to drop off the child in Dover, drive 45 miles back to Wilmington to work, drive 45 miles back to

Dover after work to pick up the child, and then drive 45 miles back to Wilmington with the child, an aggregate of 180 miles. The same analysis would apply to a single parent living and working in Georgetown who could only locate child care in Dover. The parent would have to drive 36 miles to drop off the child in Dover, drive 36 miles back to Georgetown to work, drive 36 miles back to Dover to pick up child after work, and then drive 36 miles back to Georgetown with the child, an aggregate of 144 miles. The "one hour distance" standard does not appear in the attached federal regulations, 45 C.F.R. §§261.15 and 261.56. DSS could adopt a different standard.

Second, §3011.2.1, Par. 5, recites as follows: "While a parent may not be sanctioned as a result of child care being unavailable, the parent is not exempt from TANF work participation requirements or the TANF time limits." The statement that the parent who proves the unavailability of child care may not sanctioned but "is not exempt from TANF work participation" is odd and ostensibly contradictory. If the parent proves a lack of available child care, the parent should logically be exempt from work participation. DSS may wish to review the accuracy of the recital.

I recommend sharing the above observations with the Division.

10. S.B. No.161 (Educator Evaluation System Waiver)

This legislation was introduced on January 16, 2014. It was reported out of the Senate Education Committee on January 30. As of March 3, it awaited action by the full Senate. An identical bill (S.B. No. 168) was introduced later but remains in the Senate Education Committee.

As background, Delaware law establishes the Delaware Performance Appraisal System II (DPAS II) which applies to administrators, teachers, and specialists. See Title 14 Del.C. §§1270-1275. Assessments are completed annually and results are compiled in reports published on the Department of Education's website.

Numerous articles have been published critical of the DPAS II. See attachments.

The attached November 7, 2013 News Journal editorial decried the obvious "disconnect" between glowing educator assessments and poor overall student performance:

> Overwhelmingly, Delaware teachers "aced" the test designed to rate their instructional effectiveness - only 1 percent of teachers scored "ineffective." ...However, their daily audience - the state's students - are not witnessing the same success, and the unfortunate proof is in their critical standardized test scores.

The vast majority of educators confirm that the current system "needs improvement". See attached News Journal article, Rep. John Kowalko and Rep. Kim Williams, "An education rule that defies plain old common sense" (February 21, 2014).

Current Delaware law is unclear on whether the DCAS II system applies to all public schools, including charter schools. Compare Title 14 Del.C. §1270(a) [referring to "public schools"] with 14 Del.C. §§1270(d)(e)(f)(g), 1272, 1273, and 1274 [referring only to local districts]. The DOE regulations ostensibly apply the DCAS II to all public schools. See 14 DE Admin Code 106A, §2.0 (definition of "board") and 4.0; 14 DE Admin Code 107A, §2.0 (definition of "board") and 4.0; and 14 DE Admin Code 108A, §2.0 (definition of "board") and 4.0.

S.B. No. 161 amends only 14 Del.C. §1270(f). This subsection currently allows local school districts to apply for a waiver authorizing abandonment of the DCAS II evaluation system based on adoption of a "local" evaluation system. The legislation would expand the waiver option to clarify that Vo-tech districts and charter schools could also apply for such a waiver. The legislation also deletes a requirement that schools obtaining a waiver must still evaluate initial licensees pursuant to the DCAS II system.

I have two (2) recommendations.

First, I recommend opposition to the legislation which expands the authority to solicit an "opt out" of the DCAS II to all charter schools and Vo-tech districts. This could result in dozens of separate appraisal systems for educators. One of the main benefits of the current DCAS II is the ability to compare data statewide based on a uniform system. This benefit is lost if schools can "opt out" of the DCAS II through a waiver process resulting in a "hodgepodge" of evaluation systems. Moreover, if schools are allowed to "opt out" of the DCAS, the balance of statutory requirements would no longer apply. For example, the statutory requirement (§1272) of an improvement plan for educators with an "unsatisfactory" DCAS II rating would be inapplicable. DOE guidelines for professional development (§1272) would also be inapplicable.

Second, existing law authorizes local school districts to create local educator assessment systems as a supplement to the DCAS II. See Title 14 Del.C. §§1270(d)(e). Thus, local districts who feel that the DCAS II is deficient can employ additional assessments of educators. Use of such supplemental assessments does not exempt the district from participation in the DCAS II. It would make sense to expand this authorization to charter schools and Vo-tech districts so these entities could also adopt secondary evaluation techniques in their discretion. This has the advantage of allowing for experimentation with other methodologies and approaches.

The Councils may wish to submit conforming commentary to policymakers.

11. S.B. No. 163 (Endangering Welfare of Child)

This legislation was introduced on January 29, 2014. As of March 3, it remained in the Senate Judiciary Committee.

Consistent with the synopsis, the legislation is intended to "allow prosecution for endangering the welfare of a child if the person had reason to know that the child was witnessing the crime(s)." The proposed statutory amendment is as follows:

> (a) A person is guilty of endangering the welfare of a child when:
>
> ...(4) The person commits any violent felony, or reckless endangering second degree, assault third degree, terroristic threatening, or unlawful imprisonment second degree against a victim, knowing or having reason to know that such felony or misdemeanor was witnessed, either by sight or sound, by a child less than 18 years of age who is a member of the person's family or the victim's family.

Two considerations may provide reason to reflect on the merits of the bill.

First, consistent with the attached Title 11 Del.C. §231, there are standard definitions of the required state of mind which apply to criminal offenses. There is no definition of "reason to know" and the term is not common in the criminal law. This may result in a lack of uniform interpretation of the term.

Second, consistent with both §231(c) and the attached Title 11 Del.C. §255, there is already a "reason to know" component to determination of whether a perpetrator acts knowingly. If a perpetrator is aware of a high probability that a child may be witnessing the violent crime, the "knowing" standard is ostensibly met.

I recommend that the SCPD take no position on the bill while sharing the above observations with policymakers. A courtesy copy could be forwarded to the Public Defender to facilitate input from an agency with more experience in interpretation of the Criminal Code.

12. H. B. No. 229 (Conditional Driver's License)

As background, the attached Title 21 Del.C. §4177K requires the 6-month revocation of the driver's license of adults convicted of drug offenses and juveniles determined delinquent based on drug offenses. In his 2014 State of the State address (excerpt attached), Governor Markell questioned the wisdom behind the law:

Many offenders guilty of drug offenses are denied a driver's license -regardless of whether their crime had anything to do with a car. The penalty is just one more punishment that prevents them from seeking employment and accessing job training. This should change. I ask you to eliminate the arbitrary loss of a drivers' license for crimes that have nothing to do with automobiles.

H.B. No. 229 does not contemplate repeal of the problematic law. It reflects a more restrained approach by expanding the justification for covered offenders to qualify for a conditional license. The proposed statutory amendment is as follows:

> (c) When a driver's license is revoked pursuant to this section, any such individual not in violation of probational requirements regarding substance abuse treatment shall be permitted to apply for a conditional license for the limited purpose of employment, to attend school or job training, to attend treatment appointments and to meet with their probation officer.

The legislation merits endorsement since the lack of a driver's license undermines rehabilitation efforts. Consistent with attached Fact Sheet, "The Value and Role of Work During Recovery from Mental Illness (January, 2014), engaging in employment and vocational activities is therapeutic and decreases long-term public services costs. Moreover, for families participating in the TANF program, the inability of family members to attend school or job training may result in disqualification from benefits for the entire household. See 17 DE Reg. 897 (March 1, 2014).

However, the legislation could be improved. Similar statutes authorizing conditional/restricted licenses authorize restoration of a license if justified by "critical need" or "urgent need" or "extreme hardship" based on regulations adopted by the Division of Motor Vehicles. See Title 10 Del.C. §1009(f)(2)(3); 21 Del.C. §2118(r); 21 Del.C. §4166(I); and 21 Del.C. §4177E. For perspective, I am attaching some of the DMV regulations - 2 DE Admin Code Parts 2210, 2211, and 2212. /For example, Part 2212 contains the following standard for requests for a conditional license based on "urgent need":

> 4.5.3. An urgent need by the applicant or within the family, which is critical to the family's health or welfare, and no other family members are capable of satisfying such urgent need. This includes medical facilities, child, or adult care facilities.

The Family Court statute authorizing a conditional license based on "critical need" similarly contains the following standard:

> (2) A critical need shall include loss of meaningful employment opportunity, or loss of a school opportunity, or any other urgent need of the child or the child's immediate family the continuation of which is critical to the best interests of the child but only if and for so long as no other member of the immediate family is realistically capable of satisfying such urgent need.

Title 10 Del.C. §1009(f)(2).

It would be preferable for H.B. 229 to be amended to add a "critical need" or "urgent need" justification for applying for a conditional license. Otherwise, DMV lacks the authority to grant a conditional license unless covered by one of the four (4) enumerated bases (employment; school or job training attendance; treatment appointments; probation officer meetings). Realistically, a host of other critical or urgent needs may arise in a family justifying the DMV to consider approving a conditional license. Consider the following substitute for lines 3-6 of the existing text to H.B. No. 229:

> (c) When a driver's license is revoked pursuant to this section, any such individual not in violation of probational requirements regarding substance abuse treatment shall be permitted to apply for a conditional license for the limited purpose of employment, to attend school or job training, to attend treatment appointments, ~~and~~ to meet with their probation officer, or to fulfill a critical need of the individual or immediate family based on regulations adopted by the Division of Motor Vehicles.

I recommend sharing the above observations with policymakers, including the Governor's Office.

13. S.B. No. 162 (Possession of Deadly Weapon)

This legislation was introduced on January 23, 2014. As of March 3, it remained in the Senate Executive Committee. It is earmarked with an "incomplete" fiscal note.

The bill would expand the scope of individuals barred from possession of a "deadly weapon" or ammunition for a firearm. In general the ban would extend to adults and juveniles determined incompetent to stand trial, not guilty by reason of insanity, or guilty but mentally ill of a crime of violence. Individuals subject to the ban could petition for relief through an administrative hearing process established by Title 11 Del.C. §1448A(k). Otherwise, the ban would extend for the individual's lifetime.

A similar, but more comprehensive bill (H.B. No. 88) was defeated in the Senate. See attached articles. S.B. No. 162 essentially extracts a section (lines 9-19) of the defeated H.B. No. 88 into this separate legislation. For background, see the attached excerpt from the January 18, 2014 Delaware House of Representatives Republican Caucus e-Newsletter, "Dead Gun Bill Gives Birth to New Measure". [1]

I have the following observations.

---

[1]Prospects for enactment of S.B. No. 162 appear likely. There are ten (10) Senate co-sponsors, seven (7) of whom voted against H.B. No. 88 in June, 2013.

First, there are some technical inconsistencies in the legislation. The synopsis and one provision (lines 4-5) apply the ban to a "deadly weapon". A "deadly weapon" is defined in Title 11 Del.C. §222 as including a host of articles, including a slingshot, ice pick, bicycle chain, razor, knives with more than a 3-inch blade, and a dangerous instrument such as pepper spray. In contrast, the bill uses the term "firearm" in lines 11, 15, and 19. The statute establishing the process to request relief from the ban is also limited to "firearms". See Title 11 Del.C. §1448A(k). For consistency, the sponsors could consider an amendment clarifying that the ban in lines 9-19 only applies to firearms.

Second, historically, studies have demonstrated that individuals with mental illness are more often victims, rather than perpetrators, of crime. The synopsis to H.B. No. 88 recognized this observation: "Statistically, mental illness has little to do with homicide perpetration but conversely increases the chances of being a victim of violence." Thus gun advocates could cogently argue that persons with mental illness have more need for access to a firearm for self-defense, not less need for access. Indeed, if the legislation bans possession of a "deadly weapon", it may preclude a covered individual from carrying pepper spray in her purse for protection.

Third, the legislation does create an anomaly which may violate the federal ADA. Under existing law, adults convicted of non-felony crimes of violence automatically regain their right to purchase and possess deadly weapons after 5 years. See Title 11 Del.C. §1448(d). Moreover, individuals adjudicated delinquent for felony conduct automatically regain their right to purchase and possess a deadly weapon upon reaching age 25. See Title 11 Del.C. §1448(a)(4). In contrast, adults and juveniles found not guilty by reason of insanity or incompetent to stand trial are treated more harshly than individuals actually determined guilty of the same offense. Adults and juveniles would not regain their right to possess deadly weapons after 5 years or upon reaching age 25 respectively. As a practical matter, the statute restoring rights to juveniles upon reaching age 25 recognizes that what individuals do as children is not inherently predictive of their risk to society with maturity at age 25. Query whether it makes sense to impose a lifetime ban based on conduct occurring as a child.

The SCPD may wish to share the above observations with policymakers.

Attachments

8g:legreg/314bils
F:pub/bjh/leg/2014/314bils

STATE OF DELAWARE

GOVERNOR'S ADVISORY COUNCIL FOR EXCEPTIONAL CITIZENS
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December 18, 2013

Dr. Susan K. Haberstroh, Associate Secretary
Education Supports and Innovative Practices
Department of Education
401 Federal Street, Suite 2
Dover, DE 19904

RE: 17 DE Reg. 588 [DOE Proposed Charter Schools Regulation (December 1, 2013)]

Dear Dr. Haberstroh:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the Department of Education (DOE) proposal to adopt regulations revising charter school laws as mandated by House Bill No. 165. This legislation was signed by the Governor on June 26, 2013. The revisions include the creation of the following new section:

> The Department of Education shall administer a performance fund for charter schools, to be known as the "Charter School Performance Fund". The Department of Education shall establish eligibility requirements for applicants desiring to apply for funding, which shall include but not be limited to a proven track record of success, as measured by a Performance Framework established by the charter school's authorizer or comparable measures as defined by the Department. The Department of Education shall also establish criteria to evaluate applications for funding, which shall include but not be limited to the availability of supplemental funding from non-State sources at a ratio to be determined by the Department. The Department of Education shall prioritize those applications that have (a) developed high-quality plans for start-up or expansion or (b) serve high-need students, as defined by the Department. The fund shall be subject to appropriation and shall not exceed $5 million annually.

Title 14 Del.C. §509(m)

Council would like to share two observations on the proposed revisions.

First, House Bill No. 165 requires the Department to "establish eligibility requirements for applicants desiring to apply for funding" and "criteria to evaluate applications for funding". The proposed regulation only defines the fund without describing the actual "eligibility requirements" and "criteria to evaluate applications" contemplated by the new statute. Council assumes that perhaps the Department intends to

adopt standards at a sub-regulatory level. It would be preferable to include standards in the Part 275 regulation which contains a §6 covering "funding". This would provide an opportunity for public and stakeholder input on the standards.

Second, the statute authorizes the Department to define "high-need students". The proposed regulation adopts a rather vague standard which focuses on only one parameter, low income status:

> "High-Needs Students": means students that qualify as low economic status pursuant to Department determination.

If the Legislature intended to only prioritize students from low-income families, it would have simply adopted such a reference in the statute. During the consideration of the bill, multiple amendments were introduced in this context. See attachments. An amendment (S.A. No. 3) which solely focused on low-income students did not pass. Significantly, multiple representatives introduced amendments which prioritized not only low-income students, but also students with disabilities. See House Amendment No. 9 and House Amendment No. 11. The implication is that there was a lack of consensus on the focus of prioritization but "high-needs" students should not be simply narrowly defined to only include low-income individuals. It would be favorable if the State could encourage charter schools to develop specialized programs for students with disabilities. This would be consistent with State public policy as reflected in Title 14 Del.C. §3121. Moreover, conceptually, students with disabilities are "high needs" students. By regulation (14 DE Admin Code 1426, §6.0), students cannot be classified as IDEA-eligible unless they demonstrate significant disability-based limitations on educational performance. The GACEC therefore recommends that the DOE define "high-needs students" to include "students with disabilities".

Thank you for your consideration of our comments and recommendations. Please contact the GACEC office if you have any questions.

Sincerely,

Terri Hancharick

Terri A. Hancharick
Chairperson

TAH:kpc

CC: The honorable Matthew L. Denn, Lt. Governor
The honorable Mark Murphy, Secretary of Education
The honorable Representative Paul Baumbach, sponsor of H.A. No. 9
The honorable Representative Debra Heffernan, sponsor of H.A. No. 11
Dr. Donna Mitchell, Professional Standards Board
Dr. Teri Quinn Gray, State Board of Education
Ms. Mary Ann Mieczkowski, Department of Education
Ms. Paula Fontello, Esq.
Ms. Terry Hickey, Esq.
Ms. Ilona Kirshon, Esq.

Attachments

SPONSOR: Rep. Jaques

HOUSE OF REPRESENTATIVES
147th GENERAL ASSEMBLY

HOUSE AMENDMENT NO. 3

TO

HOUSE BILL NO. 165

AMEND House Bill No. 165 by striking lines 24 through 27 in their entirety and substituting in lieu thereof the following:

(f) If a child would qualify for a no- or low-cost breakfast or lunch under a federal national school breakfast or lunch program, beginning in the 2014-2015 school year, the charter school shall provide breakfast and lunch to the child at no or low cost to the child's family. Charter schools shall not consider whether a child would qualify for no- or low-cost breakfast or lunch under a federal national school breakfast or lunch program when making enrollment decisions.

FURTHER AMEND House Bill No. 165 by striking line 68 in its entirety and substituting in lieu thereof the following:

authority to direct transfer of such funds from future State funding allocations after the school district receives reasonable notice and an opportunity to be heard, as set forth in the rules and regulations established by the Department.

FURTHER AMEND House Bill No. 165 by striking line 87 in its entirety and substituting in lieu thereof the following:

(a) An approved charter school application, together with such conditions imposed pursuant to subsection (l) of

FURTHER AMEND House Bill No. 165 by striking line 115 in its entirety and substituting in lieu thereof the following:

contrary to the best interests of the community to be served, including both those students likely to attend the charter school and those students likely to attend traditional public schools in the community.

FURTHER AMEND House Bill No. 165 by striking line 179 in its entirety and substituting in lieu thereof the following:

the application is found by the approving authority to meet the criteria set forth in § 512 and complying with the approval process in § 511 of this title, it shall approve the

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1031470174

Released: 06/11/2013 11:53 AM

FURTHER AMEND House Bill No. 165 by striking line 198 in its entirety and substituting in lieu thereof the following:

currently operate 1 or more highly successful charter schools showing sustained high levels of student growth and achievement and

FURTHER AMEND House Bill No. 165 by striking lines 237 through 239 in their entirety and substituting in lieu thereof the following:

approving authority finds that the proposed Charter demonstrates that:

FURTHER AMEND House Bill No. 165 by striking line 302 in its entirety and substituting in lieu thereof the following:

Section 7. Amend Title 14, § 513(a) of the Delaware Code by making insertions as shown by underlining and

FURTHER AMEND House Bill No. 165 by striking line 403 in its entirety and substituting in lieu thereof the following:

charter school closure protocol to ensure timely notification to parents and employees, orderly transition of students and student records to

FURTHER AMEND House Bill No. 165 by striking line 408 in its entirety and substituting in lieu thereof the following:

for students, parents and employees, as guided by the closure protocol.

FURTHER AMEND House Bill No. 165 by striking lines 411 and 412 in their entirety and substituting in lieu thereof the following:

creditors of the school. Remaining State general fund appropriations for that school year shall be returned to each district in an amount proportionate to the number of students received by each district. Additional remaining State general fund appropriations shall be returned to the general revenue fund through the State treasury. Remaining funds received from local school districts shall be returned to each of the districts in an

FURTHER AMEND House Bill No. 165 by striking line 429 in its entirety and substituting in lieu thereof the following:

Section 11. The Enrollment Preferences Task Force established pursuant to House Bill No. 90 of the 147th General Assembly shall expressly include in its final report enrollment preferences and practices used by charter schools.

Section 12. This Act shall become effective on July 1, 2013.

SYNOPSIS

This amendment clarifies that charter schools are not allowed to factor in a potential attendee's qualification under a national school breakfast or lunch program when determining enrollment, but the charter school's obligation to provide breakfast and lunch at low or no cost to a student who would qualify for that program commences with the 2014-2015 school year.

The amendment provides for procedural due process before the Department would redirect a district's future State funding to a charter school if the district is behind on its required payments.

The amendment expressly includes in the best interest analysis the children likely to attend a traditional public school in the community. The approval process described in Section 511 is also expressly required under the amendment for a charter's approval.

The amendment adds "growth" to "achievement" in order to more accurately reflect this emphasis for Delaware education policy.

Employees are added as a factor in the charter school closure protocol.

The amendment proportionately returns funds from the State's general appropriations to the districts that receive those students for the school year in which the charter school closed.

The Enrollment Preferences Task Force from House Bill No. 90 is specifically charged with reporting on charter school enrollment preferences and practices.

The amendment corrects a few technical items, including a cross-reference, a notation that a section of the bill only amends a subsection of the Code, and a repetition of two lines.

SPONSOR: Rep. Baumbach

HOUSE OF REPRESENTATIVES
147th GENERAL ASSEMBLY

HOUSE AMENDMENT NO. 9

TO

HOUSE BILL NO. 165

AMEND House Bill No. 165 by striking line 82 in its entirety and substituting in lieu thereof the following:

developed high-quality plans to serve a high proportion of traditionally under-served students including students with low socio-economic status (SES) and students with disabilities.

SYNOPSIS

The amendment requires that the high-quality plans for the receipt of funds directly serve traditionally under-served students.

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SPONSOR: Rep. Heffernan

HOUSE OF REPRESENTATIVES
147th GENERAL ASSEMBLY

HOUSE AMENDMENT NO. 11

TO

HOUSE BILL NO. 165

AMEND House Bill No. 165 by striking line 82 in its entirety and substituting in lieu thereof the following:

developed high-quality plans to serve a high proportion of traditionally under-served students including students with low socio-economic status (SES), rural students, and students with disabilities, with those schools receiving at least 50% of the performance fund.

SYNOPSIS

The amendment requires that preference is given to high-quality plans directly serving traditionally under-served students, rural students, or students with disabilities. Those programs are to receive at least 50% of the fund.

HD : SLT : LLB
1941470188

Released: 06/11/2013 01:22 PM

STATE OF DELAWARE

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January 16, 2014

Dr. Donna Mitchell, Executive Director
Professional Standards Board
Townsend Building
401 Federal Street
Dover, DE 19901

RE: Professional Standards Board Revised Proposed Paraeducator Permit Regulation [17 DE Reg. 683 (January 1, 2014)]

Dear Dr. Mitchell:

The Governor's Advisory Council for Exceptional Citizens (GACEC) reviewed the Professional Standards Board proposal, in conjunction with the Department of Education, to adopt revisions to its regulation covering paraeducator permits published as 17 DE Reg. 591 in the December Register of Regulations. A copy of our comments is attached for your reference. In that letter, Council noted that there appeared to be an error in the Register of Regulations in terms of the deadline for comments. The Register stated that "Persons wishing to present their views regarding this matter may do so in writing by the close of business on the 1st day of December, 2013…" Council noted that this should be the 1st day of January, 2014 since the Register of Regulations is published on December 1. A response was received from the Professional Standards Board stating the following:

> *Thanks so much Kathie. I received the comments. We realized the error in impact analysis immediately upon publication and have resubmitted the regulation for an additional month of public comments. We will look to see what other corrections may be made in second publication as well.*

The Department has now reissued the proposed regulation. The only difference between the December and January versions is that §§1.0 and 2.0 of the regulation are included in the publication. Since there are no proposed amendments to §§1.0 and 2.0, Council would like to thank you for reissuing the proposed regulation and reiterate our earlier comments. Those observations are as follows:

First, §§3.1.1.4 and 3.1.2.4 are grammatically incorrect. The other subparts begin with nouns ("completion"; "receipt"; and "completion" while this subpart begins with a verb ("submits"). Moreover, the reference to "and meets all the requirements" is redundant since §3.1 and 3.1.2 already require the applicant to meet listed standards. Compare analogous regulations (e.g. 14 DE Admin Code 1520, §3.0; 14 DE Admin Code 1521, §3.0). Council recommends consideration of the following substitute: "Submission of sufficient verifiable evidence to the Department that the applicant meets the above qualifications."

Second, §3.2.1 literally allows an applicant to submit either transcripts or tests scores. Council recommends substituting "and" for "or" since §§3.1.1 and 3.1.2 require both completion of education studies and satisfactory score on a test/assessment.

Third, the grammar in §4.2 is incorrect. Consider inserting "who" between "applicant" and "has".

Fourth, the grammar in §5.2 is incorrect. Consider inserting "who" between "Paraeducator" and "has".

Thank you for your consideration of our comments and recommendations. Please contact the GACEC office if you have any questions.

Sincerely,

Terri Hancharick

Terri A. Hancharick
Chairperson

TAH:kpc

CC: The Honorable Mark Murphy, Secretary of Education
Dr. Teri Quinn Gray, State Board of Education
Ms. Mary Ann Mieczkowski, Department of Education
Ms. Susan Haberstroh, Department of Education
Ms. Paula Fontello, Esq., Department of Education
Ms. Terry Hickey, Esq., Department of Education
Ms. Ilona Kirshon, Esq., Department of Justice

Attachments

STATE OF DELAWARE

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January 16, 2014

Dr. Susan K. Haberstroh, Associate Secretary
Education Supports and Innovative Practices
Department of Education
401 Federal Street, Suite 2
Dover, DE 19904

RE: 17 DE Reg. 679 [DOE Proposed Curricula Alignment with State Content Regulation (January 1, 2014)]

Dear Dr. Haberstroh:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the Department of Education (DOE) proposal to conduct an extensive revision of its standards covering the alignment of school district curricula with State content standards to address Senate Substitute No. 1 for House Bill No. 47. This legislation was enacted in 2005. It stressed the benefits of alignment of district curricula with uniform academic standards and directed districts to submit evidence of alignment to the Department of Education. Council observes that the current regulation is very rigid in defining the documentation that districts must submit to prove alignment of their curricula with State content standards. See §6.0. The proposed standards are less rigid and rigorous. The GACEC would like to share the following observations on the proposed revisions.

First, the proposed regulation contains the following provision covering special populations, including students with disabilities:

> 5.0. Documentation for Specific Student Populations
>
> As part of its documentation, the district shall explain modifications or enhancements to curricula for specific subgroups such as students with disabilities, gifted students, English learners or any other special population of students and certify alignment to the State Content Standards.

This is a variation on current §6.2.1and Council appreciates its retention in the proposed regulation.

Second, in §2.0, definition of "Evidence", there is a plural pronoun ("their") with a singular antecedent ("district"). Council recommends substituting "its" for "their".

Third, the standards appear to have transformed from one extreme to the other. The current standards include more specific and more objective criteria based on assessments and data. For example, §6.1.1 requires an analysis of "disaggregated student performance data on state assessments over the most recent three year period." Section 6.1 requires documentation of alignment by grade clusters, i.e., K-2, 3-5, etc. This concept is absent from the proposed regulation. Section 6.1.2 contemplates completion of a survey process ["Survey of Enacted Curriculum (SEC)] sponsored by the Council of Chief State School Officers resulting in an objective Alignment Index of .50 or higher. The Department may wish to consider whether the proposed standard criteria may be considered too general.

Thank you for your consideration of our comments and recommendations. Please contact the GACEC office if you have any questions.

Sincerely,

Terri Hancharick

Terri A. Hancharick
Chairperson

TAH:kpc

CC: The Honorable Mark Murphy, Secretary of Education
Dr. Donna Mitchell, Professional Standards Board
Dr. Teri Quinn Gray, State Board of Education
Ms. Mary Ann Mieczkowski, Department of Education
Ms. Paula Fontello, Esq.
Ms. Terry Hickey, Esq.
Ms. Ilona Kirshon, Esq.

STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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410 FEDERAL STREET, SUITE 1
DOVER, DE 19901

VOICE: (302) 739-3620
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MEMORANDUM

DATE: December 23, 2013

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

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

RE: 17 DE Reg. 608 [DFS Proposed Child Placing Agency Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Services for Children, Youth and Their Families/Division of Family Services (DFS)/Office of Child Care Licensing's (OCCL's) proposal to amend its regulations regarding the *Delacare Requirements for Child Placing Agencies*. The proposed regulation was published as 17 DE Reg. 608 in the December 1, 2013 issue of the Register of Regulations. SCPD has the following observations

In July 2013, the DFS published regulations revising its standards applicable to child placing agencies. SCPD submitted twenty-eight (28) comments on the proposed standards. A copy of the July 25, 2013 SCPD memo is attached for facilitated reference. Rather than adopt a final regulation, the Division is publishing a revised set of proposed regulations. SCPDs analysis will follow the order of commentary in the July 25 memo earmarked with italics.

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

Revision: The word "means" was inserted.

2. In §5.0, definition of "Child Appointed Special Advocate", substitute "litem" for "lite". SCPD also recommends 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.

Revision: DFS substituted "neglected or dependent child" for "neglected and dependent child". It deleted the reference to Guardian ad lite(m). It substituted "Court Appointed Special Advocate" for

"Child Appointed Special Advocate".

3. In §5.0, 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 §5.0.

Revision: DFS adopted a variation of the suggested language.

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

Revision: The extraneous "and" was deleted.

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.

Revision: DFS amended the provision to require posting "at the address of the Agency's actual site where services are being provided."

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.

Revision: No change was made. SCPD still recommends that the regulation include some provision for notice to affected individuals.

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.

Revision: DFS added a §18.8 which recites as follows: "A Licensee shall not discourage, inhibit, penalize or otherwise impede any staff member from reporting any suspected or alleged incident of child abuse or neglect." This is identical to §44.3. However, the provision could be improved. First, it could be modified to cover volunteer reporting as well. See analogous DFS regulation, 9 DE Reg. 105, §13.1.13.2. Second, neither §44, §17, nor §18 bar a provider from retaliating against staff who have cooperated with a post-report DFS investigation. Non-retaliation provisions facilitate State agency investigations and support sanctions if a provider penalizes cooperating staff.

Cf. Title 16 Del.C. §§1134(g), 1135, and 1154(b). Based on these concerns, the following standard could be adopted: "A Licensee shall not discourage, inhibit, penalize or otherwise impede any staff member or volunteer from reporting any suspected or alleged incident of child abuse or neglect or cooperating with a Department investigation of the incident." The term "Department" is used based on §18.2.

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.

Revision: No change was made. SCPD still supports this recommendation. In addition, SCPD respectfully requests clarification whether or not DFS consulted the Attorney General's Office in this context.

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.

Revision: Section 19.2.3 has been amended to cross reference the definition of abuse or neglect in Title 10 Del.C. §901(1). That statute defines abuse as including exploitation. SCPD still recommends that DFS expand the list of reportable incidents. An elopement or attempted suicide without injury would not be reportable incidents under the current §19.0. The cited DHSS regulations, by analogy, would require reporting of such events.

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.

Revision: No change was made. SCPD still supports this recommendation.

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.*

Revision: No change was made. SCPD still believes that Section 42.4 is overbroad and encourages DFS to revisit this issue.

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.*

Revision: No change was made. SCPD still believes that Section 42.6 would literally require the licensee to fire anyone "indicted" but not convicted of certain offenses, and is therefore ostensibly inconsistent with federal guidance previously shared with DFS.

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 §71.1which 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.

Revision: DFS amended the sentence as follows: "Staff shall ~~not contact~~ follow the protocol(s) of the investigating agency regarding informing 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 is being conducted". The phrase "is being conducted" is redundant and should be deleted.

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

Revision: DFS deleted §75.0 in its entirety. The previous version was as follows: "A licensee shall ensure that a foster parent does not subject a child to exploitation in any form." The concept is not explicitly addressed in §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.

Revision: DFS amended the reference to bar "locking a child in a room". See new §77.1.4.

16. Section 78.1.6 could be embellished with conduct (e.g. throwing child; hitting with closed fist) prohibited by Title 11 Del.C. §468(1)c.

Revision: Instead of embellishing this subsection with conduct which is prohibited by the statute, DFS deleted the specific references to prohibited conduct altogether. See new §77.1.6. It would be preferable to retain the specific examples of prohibited conduct, including shaking, hair pulling, slapping, pinching, and spanking. Many individuals would not view shaking, slapping, etc. as forms of corporal punishment.

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

Revision: DFS converted multiple references in new §77.0 to present tense.

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

Revision: The insertion was made in new §77.1.12.

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.

Revision: DFS added a new §77.1.7 barring chemical restraint and physical restraint.

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.

Revision: DFS deleted the following ban on mechanical restraint which appeared in §78.1.7: "A child shall not be tied, taped, chained or caged or place(d) in mechanical restraints as a consequence of inappropriate behavior." This is a major, unfortunate amendment. SCPD strongly recommends reinstatement of the sentence or a variation of the sentence. Otherwise, there is not prohibition on use of mechanical restraint.

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

Revision: The correction was made in new §79.2.

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.

Revision: New §79.5.1 has been added which addresses not only bumper pads, but pillows and "other soft products" as well.

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 18th birthday is not prudent. DFS should also consider adding other preparation/orientation activities, including completion of selective service registration. SCPD recommends 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?

Revision: The word "approaching" was inserted. No other change was made.

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?

Revision: No change was made. SCPD still believes that Section 90.1 is somewhat "overbroad" since it does not address the passage of time or rehabilitation, and encourages DFS to revisit this issue.

25. Section 96.1 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.

Revision: No change was made. SCPD still supports this observation and encourages DFS to revisit this issue.

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.

Revision: No change was made. SCPD still believes that DFS should add a standard addressing potentially dangerous pets.

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

Revision: DFS provided the following response to the comment: "This prohibition is consistent with the recommendations of the American Academy of Pediatrics as found in Caring for Our Children, National Health and Safety Performance Standards, Guidelines for Early Care and Education, Third Edition which states that "helmets can be a potential strangulation hazard if...worn for activities other than when using riding toys." (P. 286)." SCPD was unable to review the text of the above guidelines. The 2011 publication is available for purchase. However, further research corroborates the response. Consistent with the attached press release, the Consumer Products Safety Commission warns that children should not wear bike helmets when playing on playground equipment based on a strangulation risk.

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".

Response: The change was made.

SCPD has a few supplemental comments on the revised proposed regulation.

1. In §5.0, DFS may wish to revise the definition of "complaint investigation". The definition limits the term to investigations by the OCCL. However, §18.2 contemplates investigations by the Department's Institutional Abuse Investigation Unit in some cases.

2. In §5.0, the definition of "guardian" overlooks the concurrent authority of the Court of Chancery to also appoint guardians of children. See Title 12 Del.C. §3901(a).

3. In §44.5.1, DFS should substitute "incident" for "incidence".

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

cc: Ms. Vicky Kelly
Mr. William Love
Mr. Brian Posey
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

P&I/17reg608 dscyf-dis child placing registry 12-23-13

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

MEMORANDUM

DATE: January 8, 2014

TO: Ms. Elizabeth Timm
Division of Family Services

FROM: William Love, Director

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

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

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

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

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

Thank you for the opportunity to comment.

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

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Center for Medicaid and CHIP Services

SMD# 13-002
ACA #25

RE: Affordable Care Act Section 4106 (Preventive Services)

February 1, 2013

Dear State Medicaid Director:

This letter provides guidance to states on section 4106 of the Affordable Care Act. Section 4106(b) establishes a one percentage point increase in the federal medical assistance percentage (FMAP) effective January 1, 2013, applied to expenditures for adult vaccines and clinical preventive services to states that cover, without cost-sharing, a full list of specified preventive services and adult vaccines. In that circumstance, the increase would apply to such expenditures whether the services are provided on a fee-for-service (FFS) or managed care basis, or under a benchmark or benchmark-equivalent benefit package (referred to as an alternative benefit plan).

The specified preventive services are those assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF), and approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). The services remain optional with one exception: effective January 1, 2014, the law requires that alternative benefit plans cover preventive services described in section 2713 of the Public Health Service Act as part of essential health benefits. Section 2713 includes, among others, the same services as those authorized for increased match under section 4106 of the Affordable Care Act.

The federal Agency for Healthcare Research and Quality supports the USPSTF, an independent panel of experts in prevention that makes recommendations on clinical preventive services on a graded scale. The Centers for Disease Control and Prevention supports the ACIP, a group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. Both groups publish their recommendations. A list of the services that are eligible for the increased FMAP can be found on the following websites:

http://www.uspreventiveservicestaskforce.org/uspstf/topicsprog.htm http://www.cdc.gov/vaccines/schedules/hcp/adult.html

In order for states to claim the one percentage point FMAP increase for these services, states must cover in their standard Medicaid benefit package all the recommended preventive services and adult vaccines, and their administration, and must not impose cost-sharing on such services. States' utilization review and approval procedures should conform to USPSTF and ACIP

periodicity or indications where specified. States should ensure that they have appropriate codes or modifiers available for providers to utilize a crosswalk from those codes and modifiers to the USPSTF and ACIP recommendations, and a financial monitoring procedure to ensure proper claiming for federal match.

The one percentage point increase to the FMAP under section 4106 applies only to certain federal matching rates specified in section 1905(b) and section 1905(y) of the Social Security Act (the Act). Specifically, for eligible services, section 4106 of the Act only applies to the following FMAP rates, as long as the FMAP does not exceed 100 percent:

- Regular FMAP rates calculated in the first sentence of section 1905(b) of the Act.
- FMAP rates specified in the first sentence of section 1905(b) of the Act for the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.
- The enhanced FMAP specified in section 1905(b) of the Act relating to services provided to certain breast or cervical cancer patients.
- The increased FMAP rates for Medical Assistance for newly eligible mandatory individuals specified at section 1905(y) of the Act. We note, that although the FMAP indicated in section 1905(y)(1)(A) of the Act for calendar quarters in 2014, 2015, and 2016 is 100 percent, as indicated above, this FMAP may not exceed 100 percent.

We are adding new lines to the CMS-64 report to capture state expenditures incurred in the provision of services authorized under section 4106. States should use these new line items to reflect expenditures eligible for the additional one percentage point. As with all services reimbursed under Medicaid, states are required to maintain documentation supporting expenditures claimed under these new line items. This documentation must contain the coding, crosswalk, and controls procedures discussed above and must be made available to the Centers for Medicare & Medicaid Services (CMS) upon request.

Overlap with Other Services

We recognize that provision of the preventive services described in section 4106 may occur at the same time as other services eligible for enhanced or increased FMAP rates not identified above. For example, family planning services may include USPSTF preventive services and ACIP approved adult vaccines, and their administration, furnished during a family planning visit. Family planning services can be reimbursed at a 90 percent rate. In these cases, states should claim on the family planning line of the CMS-64 form, which is reimbursed at the 90 percent rate. If a state ordinarily claims these preventive services and adult vaccines as a separate service from the family planning service, it should continue to do so.

Certain USPSTF grade A or B preventive services and vaccine administration codes eligible for the one percentage point FMAP increase under section 4106 may also qualify as primary care services eligible for a temporary increase in the payment rates matched at 100 percent federal financial participation (FFP) for calendar years (CY) 2013 and 2014 per section 1202 of the Affordable Care Act. Under section 1202, the Medicaid rate in CYs 2013 and 2014 for such primary care services by or under the direction of an eligible physician will be the lower of the provider's charges or the 2013 and 2014 Medicare rate respectively. FFP is available for 100

percent of the difference between the Medicaid rate as of July 1, 2009 and the increased rate. Under section 1202, the state's regular FMAP rate will be available for the portion of the rate related to the July 1, 2009 base payment. An additional one percentage point will be available on that base amount under section 4106 of the Affordable Care Act. The following example illustrates the interaction of these two Affordable Care Act provisions.

> **Example**. A state's regular FMAP is 60 percent and under section 4106 of the Affordable Care Act, the FMAP would be increased to 61 percent for certain affected preventive services effective January 1, 2013. The portion of the state's rate related to the July 1, 2009 base payment for certain affected primary care preventive services is $70. In 2013 the state increases the rate to $80 in accordance with section 1202 of the Affordable Care Act. The $10 difference between the $70 July 1, 2009 Medicaid rate and the increased rate of $80 is eligible under section 1202 of the Affordable Care Act for 100 percent FMAP. Prior to the application of the Affordable Care Act provisions, the total federal funding for the $70 provider payment rate would have been **$42** (60 percent FMAP of $70). With the application of section 4106 and 1202 of the Affordable Care Act, the total federal funding available would be **$52.70**, calculated as $42.70 (61% (60 percent FMAP plus one percentage point) of the $70 regular provider rate) plus $10 (100 percent of the difference between $80 (the increased provider rate) and $70 (the July 1, 2009 rate)).

Claiming the Increased FMAP in Managed Care

In order to be eligible for the one percentage point increased FMAP, states must make these services available to those enrolled in a managed care delivery system as well as those in a FFS setting, and must ensure that beneficiaries have no cost-sharing liability for these services. States have the authority to claim an increased FMAP for preventive services whether provided in a FFS setting or in a managed care program that is reimbursed through capitation rates that meet the requirements for actuarial soundness in 42 CFR 438.6(c).

The portion of the capitated rate that is attributable to preventive services and upon which an increased match may be claimed, may be determined prospectively based upon historical FFS data or data from the managed care plans (if available). The portion of the capitation rate claimed at the increased FMAP must be attributable only to services meeting the definition for preventive services under this section. The data used to establish the portion of the capitation rate that can be claimed at the increased FMAP rate should be the most recent complete and validated historical data available, whether from FFS or the managed care plans. In order to claim the increased FMAP states may need to amend their managed care contracts to require delivery of these services in accordance with the statute.

State Plan Modifications

States seeking the one percentage point FMAP increase should amend their state plans to reflect that they cover and reimburse all USPSTF grade A and B preventive services and approved vaccines recommended by ACIP, and their administration, without cost-sharing. States should provide an assurance in the state plan indicating that they have documentation available to support the claiming of federal match for such services, as described earlier in this letter. States

should provide an additional assurance stating that they have a method to ensure that, as changes are made to USPSTF or ACIP recommendations, they will update their coverage and billing codes to comply with those revisions. Please refer to the previously mentioned websites for USPSTF and ACIP updates.

Additional Policy Development

Certain preventive services listed by the USPSTF when provided by non-licensed practitioners have traditionally not been covered by Medicaid due to regulatory requirements limiting practitioners of preventive services to either physicians or licensed professionals. Although section 1905(a)(13) of the Act contains broad language authorizing payment for preventive services recommended by a physician or other licensed practitioner, the implementing regulation at 42 CFR 440.130(c) currently limits preventive services to those provided by a physician or other licensed practitioner of the healing arts (within the scope of practice under state law). Consistent with 4106(a), CMS proposed revisions to this regulation in the Notice of Proposed Rulemaking which went on display in the Federal Register on January 14, 2013, giving states the ability to recognize unlicensed practitioners in the delivery of these services. Should this policy be finalized, states would be able to claim the one percentage point match for preventive services delivered by practitioners other than physicians or other licensed practitioners. Until that time, however, the increased match is available only for those services that are delivered in accordance with existing Medicaid regulations.

We are eager to work with states to facilitate the implementation of these preventive services that can improve the health of beneficiaries. As you continue to consider and implement measures aimed at strengthening prevention, we are available to provide technical assistance on prevention related topics if you email us at: MedicaidCHIPPrevention@cms.hhs.gov. If you have any questions regarding this letter, please contact Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-0325.

Sincerely,

/s/

Cindy Mann
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health Operations

Matt Salo
Executive Director
National Association of Medicaid Directors

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Ronald Smith
Director of Legislative Affairs
American Public Human Services Association

Joy Wilson
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National Conference of State Legislatures

William Garner
Legislative Director
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christopher Gould
Director, Government Relations
Association of State and Territorial Health Officials

Questions & Answers on ACA Section 4106
Improving Access to Preventive Services for Eligible Adults in Medicaid

STATE PLAN AMENDMENT (SPA)

Q1. Can a state submit a SPA to implement section 4106 at any time?

A1. Yes, a state may submit a SPA at any time. The one percentage point increase in federal medical assistance percentage (FMAP) per the requirements outlined in section 4106 of the Affordable Care Act does not have an end date.

Q2a. The state is under the impression that they only need to update the 3.1-A coverage pages for preventive services to claim the 1% FMAP increase. Does the state need to update their reimbursement pages as well to provide the required assurances?

Q2b. Can you please advise if CMS will require public notice in addition to the SPA for the 1% FMAP increase to take effect?

A2. In order to receive the one percentage point FMAP increase, the state is required to submit a SPA with updated coverage pages. When a SPA is submitted with updated coverage pages, we will perform a review of the corresponding payment page(s). A state does not need to submit a SPA with revised payment pages, and conduct public notice, unless it wishes either to begin coverage and payment for these services or to change the existing payment rates (in other words, if the state already pays for the preventive services in some contexts, a payment SPA may not be needed if the state does not want to change the existing payment rate or methodology).

Q3. Under what portion of the state plan should the state add the Affordable Care Act section 4106 information?

A3. The preventive services information should be placed in item (13)(c), preventive services, of the pre-print. The State Medicaid Director (SMD) letter #13-002 indicates the information that should be added to the 3.1-A (and at the state's option, the 3.1-B) coverage limitations pages. CMS is available to provide technical assistance before you submit the SPA, or we can discuss the needed information during the review of your SPA.

Q4. Is there a SPA pre-print the states can use to comply with section 4106 of the Affordable Care Act or is CMS planning to issue one?

A4. For states seeking the one percentage point FMAP increase, the state plan amendment requirements are indicated on pages 3 and 4 of SMD letter #13-002. CMS will not provide a state plan template on section 4106 of the Affordable Care Act. However, staff are available to provide technical assistance prior to your SPA submission.

Q5. Does a state that has both a fee-for-service (FFS) and a managed care delivery system, get the 1% FMAP increase when just the FFS benefit is amended or would the state have to concurrently amend its managed care authority document (SPA, waiver or 1115 demonstration project) to get the 1% FMAP increase?

A5. A state would have to submit a SPA to amend the preventive services benefit in the state plan. Once that SPA is approved, the state generally is eligible for the enhanced FMAP for such services. The state should review its managed care authority document (SPA, waiver or 1115 demonstration project) to ensure that it reflects the coverage and cost-sharing provisions (as appropriate) of the preventive services benefit. The state will have to amend its Managed Care Organization (MCO) contracts to reflect the scope of coverage and the absence of cost-sharing for the preventive services benefit. To claim that enhanced FMAP for managed care payments, CMS must review the methodology that the state intends to use to estimate the value of the preventive services benefit in its capitation rates.

SERVICES ELIGIBLE FOR THE ONE PERCENTAGE POINT FMAP INCREASE

Q6. If a state elects to cover preventive services to be eligible for the one percentage point FMAP increase, must we cover all of the United States Preventive Services Task Force (USPSTF) A and B preventive services or can we cover just a few?

A6. All USPSTF grade A and B preventive services, Advisory Committee on Immunization Practices (ACIP) recommended vaccines, and their administration, must be covered without cost-sharing in order to be eligible for the one percentage point FMAP increase.

Q7. Are fluoride treatments (also known as fluoride varnishes) eligible for the one percentage point increase in FMAP under section 4106?

A7. No, fluoride varnish is not eligible for the one percentage point FMAP increase. In the future, if the USPSTF adds fluoride varnish to the A or B recommended preventive services, states will be required to cover the fluoride varnish with no cost-sharing. Per SMD letter #13-002, states should provide an assurance in the state plan indicating they have a method to ensure that, as changes are made to the USPSTF and ACIP recommendations, they will update their coverage and billing codes to comply with those revisions. As long as this assurance is in the state plan, states are not required to submit a SPA each time the USPSTF or ACIP makes changes to their recommendations.

Q8. While section 4106 of the Affordable Care Act authorizes a 1% FMAP increase for tobacco cessation services for pregnant women, the SMD letter does not address this proposed increase. Please clarify if this qualifies for the 1% FMAP increase.

A8. The USPSTF recommendation for tobacco use counseling for pregnant women is grade A. Therefore, tobacco use counseling for pregnant women shall receive the one percentage point increase in FMAP. In addition, section 4106 of the Affordable Care Act states "items and services described in subsection (a)(4)(D)". Therefore, the one percentage point increase pertains to the *comprehensive* tobacco cessation services for pregnant women that are described in section 4107 of the Affordable Care Act.

Q9. Section 4106 of the Affordable Care Act states that "any medical or remedial services [designed] for the "maximum reduction" of physical or mental disability and restoration of an individual to the best possible functional level" was also authorized to receive 1% FMAP; however, the SMD letter does

not address this provision. Please clarify if this is included, if yes, please provide information as to how this should be captured in claims data.

A9. The statute amended section 1905(b) of the Social Security Act (Act) only to provide for the higher federal matching rate for services and vaccines described in subparagraphs (A) and (B) of section 1905(a)(13) of the Act . These subparagraphs are limited to "clinical preventive services assigned a grade of A or B by the USPSTF, adult vaccinations, and comprehensive tobacco cessation for pregnant women. This is a subset of the services described in section 1905(a)(13) of the Act.

Q10a. For Medicaid eligible children, the state does not reimburse for the immunizations due to the Vaccines for Children (VFC) program. The state only reimburses for the vaccine administration code. Are the administrative codes for children's immunizations eligible for the preventive services FMAP increase?

Q10b. Can the fee for administration of the adult vaccines receive the one percentage point increase in FMAP?

A10. Section 1905(a)(13)(B) of the Act is limited to adult vaccines, therefore, the following applies:

- *Children age 18 and under*: Vaccines are provided through the Vaccines for Children (VCF program). Therefore, the one percentage point increase does not apply. For this age group, the vaccine administration fee is not eligible for the one percentage point FMAP increase.
- *Individuals age 19 and 20:* Vaccines are not available through the VCF program for this age group. This age group may receive the one percentage point increase in FMAP on both the vaccines and the vaccine administration fee.
- *Adults ages 21 and older:* Both the ACIP recommended vaccines and the vaccine administration fee are eligible for the one percentage point increase in FMAP.

Q11. In some of the recommendations, a drug is mentioned, for example, "aspirin to prevent cardiovascular disease." Does the 1% FMAP increase apply to the drug?

A11. No, the one percentage point FMAP increase does not pertain to prescribed drugs (including over-the-counter drugs prescribed by a healthcare professional) that are claimed on the "Prescribed Drugs" line of the CMS-64 form. However, the one percentage point FMAP increase applies to injectable drugs that receive a USPSTF grade A or B recommendation and are provided in a clinical setting for the primary purpose of prevention. Cost-sharing should be waived for such services.

Q12. Do we receive the 1% FMAP increase on only those services identified by the USPSTF A and B?

A12. The one percentage point FMAP increase is available only for USPSTF Grade A and B services, comprehensive tobacco cessation services for pregnant women, ACIP recommended vaccines for adults, and their administration.

Q13. In the law it is found under Adult preventive services. I noticed that the items listed in the USPSTF grade A and B services include screening for children. Does the 1% FMAP increase only apply to services provided to adults (beneficiaries ages 21 and older)?

A13. The one percentage point FMAP increase applies to the USPSTF grade A and B recommended services for the populations referenced in the recommendations.

Q14. Will the one percentage point FMAP increase apply to the expansion population after the period of 100% Federal match if the grade A and B services, etc. are covered without cost-sharing?

A14. The newly eligible FMAP (described in section 1905(y)(1) of the Act) is 100 percent in calendar years 2014-2016, 95 percent in calendar year 2017, 94 percent in calendar year 2018, 93 percent in calendar year 2019, and 90 percent in calendar years 2020 and beyond.

For states who opt to provide the services mentioned in section 4106 of the Affordable Care Act without cost sharing, for calendar years 2014-2016, the one percentage point increase for newly eligible individuals wouldn't apply, as the FMAP for that group is 100 percent.

Starting in 2017 and beyond, when the newly eligible FMAP goes to 95 percent and below, the one percentage point increase for the services mentioned in section 4106 of the Affordable Care Act would apply to the newly eligibles. Example: For 2017, newly eligibles would receive 95 percent FMAP. If the state opts to provide the services mentioned in section 4106 of the Affordable Care Act without cost sharing, per the guidelines in SMDL 13-002, the state would receive 96 percent FMAP on such services for the newly eligibles.

Q15. Is it correct that any family planning service that also appear in services recognized under section 4106 are not eligible for the 1% FMAP increase since we receive a 90% match already?

A15. Yes, that is correct. The one percentage point FMAP increase under section 4106 applies only to the FMAP set forth under section 1905(b) and section 1905(y) of the Act; it does not apply to FMAP rates under section 1903(a) of the Act. However, any family planning related service that also is recognized by section 4106 and matched at the state's regular FMAP is eligible to receive the one percentage point FMAP increase.

Q16. Do we receive a 1% FMAP increase for services provided to beneficiaries who have other health insurance coverage besides Medicaid?

A16. If the state is meeting the requirements outlined in SMD letter #13-002, the state may receive the one percentage point FMAP increase on the Medicaid liability after coordination of benefits occurs.

Q17. Per state statute, my state currently covers breast cancer screenings at the USPSTF Grade C level. Breast cancer screenings are on the USPSTF list as a Grade B service with a different periodicity level. Will we still be eligible for the 1% FMAP increase if we cover the breast cancer screening at the USPSTF Grade C level, but cover all of the other USPSTF Grade A and B services, ACIP recommended vaccines, and their administration without cost-sharing?

A17. All USPSTF grade A and B services, and ACIP recommended vaccines and their administration, must be covered without cost-sharing in order to be eligible for the one percentage point FMAP increase. The Department of Health and Human Services, in implementing the Affordable Care Act under the standard set out in revised section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendations on breast cancer screening of the USPSTF. Therefore, we are adopting a flexible approach for states to

receive a one percentage point FMAP increase for breast cancer screening. States can choose to use either the 2002 USPSTF grade B recommendation or the most current USPSTF recommendation (which is the grade B recommendation updated in 2009). The 2002 USPSTF recommendation is that women age 40 years and older should receive a screening mammography every one to two years. The 2009 USPSTF recommends biennial screening mammography for women aged 50 to 74 years of age.

Q18. Are clinical preventive services that receive an I or C recommendation ineligible for Medicaid coverage? Are they ineligible for the increased FFP?

A18. Clinical preventive services that receive an I or C recommendation are eligible for Medicaid coverage. States determine medical necessity criteria, and determine whether they will cover I or C recommended services. However, USPSTF grade I and C recommended services are not eligible for the one percentage point FMAP increase.

Q19. Are clinical preventive services that receive a D recommendation ineligible for Medicaid coverage?

A19. Clinical preventive services that receive a D recommendation are eligible for Medicaid coverage. States determine medical necessity criteria, and determine whether they will cover D recommended services. However, USPSTF grade D recommended services are not eligible for the one percentage point FMAP increase.

Q20. When will the guidance be available for whether unlicensed practitioners will be able to furnish the section 4106 services?

A20. "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment Final Rule" (CMS-2334-F), published in the Federal Register on 7/15/2013, conformed the regulatory definition of preventive services at § 440.130(c) with the statute relating to the issue of who can be providers of preventive services. Per the final rule, effective 1/1/2014, preventive services may be recommended by a physician or other licensed practitioner. Therefore, unlicensed practitioners will be able to furnish preventive services (including the services mentioned in section 4106), based on the recommendation of a physician or other licensed practitioner, according to the provider qualifications established by each respective state, within broad federal parameters. In order for states to receive the one percentage point FMAP increase for unlicensed practitioners, it is likely that a State plan amendment updating section (13)(c) of the state plan will be necessary. Please refer to the preventive service CMCS Informational Bulletin issued on November 27, 2013 for additional information regarding adding unlicensed practitioners to the preventive services section of the state plan.

BILLING, CODING, AND CLAIMING ON THE CMS-64 FORM

Q21. Can CMS recommend a list of CPT and HCPCS codes to be covered for the corresponding USPSTF grade A and B recommendations?

A21. While section 4106 of the Affordable Care Act states that USPSTF grade A and B services, ACIP recommended vaccines and their administration must be covered to secure the one percentage point

FMAP increase, it is incumbent upon state Medicaid agencies to continue to work with, and communicate to, providers concerning state-specific systems and appropriate codes. The information provided by the American Medical Association in the below link (the CPT Code Pocket Guide: Preventive services with cost-sharing waived) can be used as a starting point in creating a cross-walk from the USPSTF and ACIP recommended codes, but it is not all-inclusive.

https://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-preventive-services.page

In addition, the October 2012 State Health Official (SHO) letter, gave the below web site address for HCPCS codes effective for service dates on or after January 1, 2012, and contacts within CMS for questions regarding HCPCS codes.

http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

Q22. Is there a modifier to assist providers, payers and states in identifying preventive services?

A22. The American Medical Association created modifier 33 in response to the Affordable Care Act requirements pertaining to preventive services. When the primary purpose of the service is the delivery of an evidence-based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending *modifier 33, preventive service*, to the service. For separately reported services specifically identified as preventive, the modifier should not be used.

Q23. Does the 1% FMAP increase apply to preventive visits (New patient preventive visit 99381-99387 and Established patient preventive visit 99391-99397) codes? These codes are not listed on the USPSTF A and B recommendations.

A23. Section 4106 of the Affordable Care Act pertains only to USPSTF grade A and B recommended services, ACIP approved vaccines, and their administration. Therefore, the one percentage point FMAP increase does not apply to preventive visits.

Q24a. If our program expects that a particular screening be done as part of an Evaluation and Management (E&M) coded visit, how does that relate to CMS coverage expectations?

Q24b. Counseling and verbal screening are often incorporated into an E&M visit. Does CMS require that states have distinct coding and reimbursement rates for physician time spent:

- **measuring blood pressure**
- **counseling about alcohol misuse**
- **making a referral for BRCA screening**
- **discussing breast cancer chemoprevention**
- **counseling on breastfeeding**
- **prescribing oral fluoride**
- **screening for depression**
- **screening for intimate partner violence**
- **screening for obesity**

- **counseling to prevent skin cancer**
- **counseling on tobacco cessation**

A24. We recognize that an E&M service may include a USPSTF grade A or B service (for example, blood pressure screening). To receive the one percentage point FMAP increase, states are required to cover in their standard Medicaid benefit package all USPSTF grade A and B preventive services, ACIP recommended vaccines, and their administration, without cost-sharing. It is up to the state to determine how the billing should occur. In the examples mentioned above, if you consider these USPSTF grade A or B recommended services to be an integral part of the office visit, and they will not be billed separately, the state may continue that billing practice. The state may claim the one percentage point FMAP increase on the office visit only if the primary purpose of the office visit is the delivery of a USPSTF grade A or B service, and not if it is simply a component part of a different billed service. The state should work with providers and payers to ensure that Current Procedural Terminology (CPT) coding and reimbursement practices for preventive medicine services are followed. We wish to confirm that a state must be able to document expenditures claimed on the CMS-64 and we believe the best way to accomplish this is through the billing process.

Q25. If the preventive service is bundled with other services, and the bundled service includes more than one preventive service, may the state allocate the bundled payment among the included services and claim the enhanced match for each of the preventive services? Example, in an annual exam, the physician provides both obesity counseling and alcohol misuse counseling. Can the state submit a claim for both the obesity counseling and the alcohol counseling?

A25.It is up to the state to set up its payment methodologies and procedures. To the extent that the state processes a claim for a USPSTF grade A or B preventive service consistent with those procedures, it can claim the enhanced match for that claim. If the state elects a payment methodology using bundled services, generally it cannot claim the enhanced match. But there may be some instances in which it might be appropriate to allocate costs for bundled claims among the included components. To the extent that a state is interested in doing so, it must develop a cost allocation plan, and submit that for CMS approval.

Q26a. The list of USPSTF preventive services describes services as being available for persons based on their sex and age range. For example: Abdominal aortic aneurysm screening (men): The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked. Are states required to follow the USPSTF grade A and B recommendations on age, gender and smoking status in order to claim the one percentage point FMAP increase for a particular service?

Q26b. Since some recommendations have start and stop ages, are states required to perform age edits on each service for each individual?

A26. States may only claim the one percentage point FMAP increase on services that adhere to the USPSTF grade A and B recommendations on age, gender, periodicity and other criteria as indicated in the summary of recommendations. For instances where the USPSTF grade A and B recommendations have expanded age, gender or periodicity levels due to clinical considerations, practitioners should document in the patient's medical record the necessity for exceeding the grade A and B recommendations, and states may claim the one percentage point FMAP increase. When billing for

these services, payers may want to use modifier 33 to identify services that meet the criteria for the USPSTF grade A and B recommendations. Pursuant to page 2 of SMD letter #13-002, states should have a financial monitoring procedure in place to ensure proper claiming for federal match.

Q27a. What diagnosis codes must be billed in order to claim the 1% FMAP increase (the USPSTF A and B does provide a list of codes – should we limit our review to them)?

Q27b. Are we required to make sure these services are for preventive screening and not for disease diagnosis? For example, anemia testing in pregnant women can be part of routine prenatal care, and a provider may order it later in a pregnancy if the woman complains of fatigue.

Q27c. The same service may be screening or diagnostic. How does CMS want states to differentiate? For example, we will pay a lab claim for a lipid panel. Having to match with the ICD code (e.g. the presence or absence of hyperlipidemia) is burdensome, and ICD code may reflect either existing condition or purpose of ruling out that condition.

Q27d. The Medicaid billing codes associated with the eligible preventive services verify that a service was provided; they do not differentiate between services that are provided for preventive reasons and services that are provided for diagnosis maintenance. We would like CMS guidance on how this differentiation is to be identified.

A27. As long as the state covers all USPSTF grade A and B services, ACIP recommended vaccines, and their administration, without cost-sharing, such services will be eligible for the one percentage point FMAP increase. State Medicaid agencies should work with, and communicate to, providers concerning state-specific systems and the appropriate codes to use.

Q28. Are states required to follow only the summary of recommendations, or other information in the recommendation statement such as frequency? If the latter, reviewing potentially a ten-year claims history (e.g. for a colonoscopy) will be extremely burdensome.

A28. Provided that the services are medically necessary, states are required to follow only the summary of recommendations for the services that have a rating of A or B from the USPSTF. It is up to the state to have a financial monitoring procedure to ensure proper claiming for federal match.

Q29. For breast screenings, may the state claim the interpretation of the x-ray for the one percentage point FMAP increase, or can only the x-ray itself be claimed?

A29. The state may claim the 1% FMAP increase on **both** the professional component (interpretation of the x-ray) and the technical component (the actual taking of the x-ray).

Q30. According to the USPSTF methodology "The Task Force also aims to update topics every 5 years, in order to keep recommendations in the Task Force library current according to criteria established by the National Guideline Clearinghouse™". Does the requirement of covering and claiming increased FFP for USPSTF A and B recommendations apply only to recommendations that are new, updated, or reaffirmed within the past five years?

A30. Yes, the one percentage point increase in FMAP applies to all USPSTF grade A and B recommendations, including new, updated, and reaffirmed within the past five years.

Q31. Providers are permitted to charge a copay for a member's office visit. This visit may include a variety of services including preventive and non-preventive services. The SMD letter indicates the enhanced FMAP is available if cost-sharing is eliminated for preventive services. We believe this to mean that the doctor cannot collect a copay for any visit in which preventive services are provided, regardless of whether the majority of services provided during the visit are non-preventive services. We would like CMS verification.

A31. If the USPSTF grade A or B service is an integral part of the office visit that includes other services, and will not be billed separately, the state may permit providers to charge a copay for the office visit, as the office visit is not eligible for the one percentage point FMAP increase. If the USPSTF grade A or B service is billed separately, or is the only service furnished during the office visit, the state may not permit the provider to charge a copay. The state should work with providers to establish the appropriate billing codes and claims processing guidelines for these situations.

Q32. What information is being required for the CMS-64 reporting requirement to claim the increased FMAP for managed care expenditures?

A32. States seeking the one percentage point FMAP increase should amend their state plans to reflect that they cover and reimburse all USPSTF grade A and B preventive services and approved vaccines recommended by ACIP, and their administration, without cost-sharing. An approved state plan amendment is required for the lines to be enterable on the CMS-64 form. As with all other services claimed on the CMS-64, the amounts reported on and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed. The CMS-64 report form has been modified to allow for reporting of a state's managed care expenditures separate from the state's reporting of FFS expenditures. The total expenditures associated with services referenced in section 4106 would be reported on the requisite lines for managed care (line 18A4, 18B1d or 18B2d) and for FFS (line 34A).

Q33. What federal matching rate will apply for services for which a higher payment is made under section 1202 of the Affordable Care Act, if the services also qualify for a higher FMAP under the provisions of section 4106 of the Affordable Care Act?

A33. States that elect to cover all USPSTF grade A and B services, ACIP recommended vaccines and vaccine administration, without cost-sharing and who receive a SPA approval for such services shall receive the one percentage point FMAP increase per section 4106. Some of these services may also qualify as primary care services eligible for an increase in the payment rates under section 1202 of the Affordable Care Act. For these services, the federal matching rate is 100 percent for the difference between the Medicaid rate as of July 1, 2009 and the payment made pursuant to section 1202 (the increase). The federal matching payment for the portion of the rate related to the July 1, 2009 base payment would be the regular FMAP rate, except that this rate would be increased by one percent if the provisions of section 4106 of the Affordable Care Act were followed.

a benign tumor, and (b) each patient for whom it renders any care after the individual is diagnosed with cancer or a benign tumor. Compliance by one health care provider with this Section with respect to an individual patient shall not obviate compliance by other health care providers with respect to the same patient.

4.0 Forms Supplied by Department

Forms prepared by the Department for use by health care providers in complying with Section [~~2~~ 3] shall request all data required by the reporting requirements of the National Cancer Data Base established by the American College of Surgeons. Forms prepared under this section shall also request disclosure of the address at which the patient has lived for the longest period of time, the occupation at which the patient has worked for the longest period of time, and the name and address of the employer at the occupation where the patient has worked for the longest period of time, if such information is available to the health care provider. A health care provider shall make reasonable efforts to obtain all information requested by the form prepared under this Section. However, reasonable efforts by a clinical laboratory shall not include the interviewing of patients to obtain required information.

5.0 Retention of Required Information

A health care provider who is treating a patient who has been diagnosed with cancer or a benign tumor shall ask that patient to fill out a form requesting disclosure of the address at which the patient has lived for the longest period of time in his or her life, the occupation at which the patient has worked for the longest period of time in his or her life, and the name and address of the employer at the occupation where the patient has worked for the longest period of time. The health care provider shall retain the form required by this Section with the patient's medical records pursuant to generally accepted protocol for the retention of patient medical records. The health care provider shall include the information from the form required by this Section with information it submits pursuant to Section [~~2~~ 3] of these regulations. The Department shall provide a form for use in complying with this Section.

6.0 Deadlines for Submission

A health care provider shall provide the information required by Section [~~2~~ 3] within 180 days of the initiation of treatment of a patient or diagnosis of that patient with a cancer or benign tumor, whichever is earlier.

7.0 Failure to Submit Required Information

A health care provider that fails to comply with Section 5 shall permit the Department to audit its records and abstract information that should have been provided under Section [~~5~~ 6]. The health care provider shall reimburse the Department for the cost of said audit. If the audit does not identify a compliance failure by the health care facility or provider, the cost of such audit shall not be assessed against the facility or provider.

8.0 Voluntary Audit

A health care provider may voluntarily request that an audit be performed if it does not intend to submit the information required by Section [~~5~~ 6]. The Department shall determine if the request for an audit will be honored. The health care provider shall reimburse the Department for the cost of said audit if the Department honors the request. The Department shall determine whether said costs shall be prepaid, or paid upon completion of the audit.

9.0 Fines

Failure to comply with Section [~~5~~ 6] of these regulations may result in a $100 fine against the health care provider that has failed to comply. Each failure to comply shall constitute a separate violation and shall subject the health care provider to a separate $100 fine.

DIVISION OF SOCIAL SERVICES

Statutory Authority: 31 Delaware Code, Section 505 (31 **Del.C.** §505)

ORDER

Nature Of The Proceedings:

Delaware Health and Social Services ("Department") / Division of Social Services initiated proceedings to amend the Title XIX Medicaid State Plan to change drug-pricing methodology, effective January 1, 2003. The Department's proceedings to amend its regulations were initiated pursuant to 29 Delaware Code Section 10114 and its authority as prescribed by 31 Delaware Code Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 Delaware Code Section 10115 in the December 2002 Delaware Register of Regulations, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by December 31, 2002 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

Summary Of Proposed Revisions

Currently, Delaware reimburses pharmaceuticals using the lower of:

- the usual and customary charge to the general public for the product,
- the Average Wholesale Price (AWP) minus 12.9% plus a dispensing fee, or
- a State-specific maximum allowable cost (DMAC) and, in some cases, the federally defined Federal Upper Limit (FUL) prices plus a dispensing fee.

The proposed State Plan Amendment (SPA) changes the AWP methodology as follows:

- Brand name drugs:
- for traditional chain pharmacies and independent pharmacies: AWP minus 16.32% plus a dispensing fee per prescription
- for non-traditional pharmacies: AWP minus 24.32% plus a dispensing fee per prescription.
- Generic drugs for all pharmacies: Average of the Average Wholesale Price (AAWP) minus 58% plus a dispensing fee per prescription.

There will be no dispensing fee increase.

The SPA also:

- clarifies terms used in the methodology process by revising the definition of the Delaware Maximum Allowable Cost (DMAC);
- provides definitions of traditional and non-traditional pharmacies; and,
- revises reimbursement limits and exceptions.

Summary of Comments Received with Agency Response and Explanation of Change:

Delaware Developmental Disabilities Council (DDDC), Delaware Healthcare Association (DHA), Governor's Council For Exceptional Citizens (GACEC), National Association of Chain Drug Stores (NACDS), and State Council for Persons with Disabilities (SCPD) submitted comments strongly opposing the Medicaid pharmacy reimbursement rate for the Delaware Medical Assistance Program, effective January 1, 2003. Comments are arranged by subject matter and summarized. Staff analysis of the public comments is provided and given a consolidated response below:

DHA comments:

- No comment period and prior notification.
- Providers did not participate in the change process.
- Recommend delay in the cuts until further discussion and negotiations occur between affected providers.

NACDS comments:

- Question the size of the audit sample and some of the audit methodology and state that Delaware dispenses fewer generics as a percentage of total prescriptions than other states.
- The pharmacy dispensing fee remains inadequate.
- Cost utilization must be addressed.

DDDC, GACEC and SCPD provided the following similar observations and concerns:

- Reductions are dramatic. Recommend DSS reconsider the drastic reductions and review other options with pharmacies.
- Discuss other cost-cutting alternatives adopted by other states.
- Limits on physician authorization for a name-brand drug.
- Recommend that DSS solicit the Delaware Health Fund Advisory Committee to determine if "tobacco funds" can be used to offset the proposed cost-cutting approaches in order to reach a compromise with the pharmacies.

DSS Response: In response to comments received, the proposed amendment has been revised and the pharmacy policies and rate plans changed and clarified as follows:

- Brand name drugs:
- for traditional pharmacies: AWP-14% plus dispensing fee per prescription;
- for non-traditional pharmacies: AWP-16% plus dispensing fee per prescription.
- Generic drugs:
- for traditional pharmacies: AWP-14% plus dispensing fee per prescription;
- for non-traditional pharmacies: AWP-16% plus dispensing fee per prescription.

The dispensing fee will remain at $3.65.

Findings Of Fact:

The Department finds that the proposed changes as set forth in the December 2002 Register of Regulations should be adopted, as herein, revised.

THEREFORE, IT IS ORDERED, that the proposed regulations of the Medicaid/Medical Assistance Programs to amend the Title XIX Medicaid State Plan related to the reimbursement of pharmaceuticals be adopted, as herein revised, and shall be final effective February 10, 2003.

Vincent P. Meconi, Secretary, DHSS, January 15, 2003

DRUG CHANNELS
Expert Insights on Pharmaceutical Economics and the Drug Distribution System

TUESDAY, FEBRUARY 18, 2014

How Medicaid is Squeezing Specialty Pharmacy Profits

An Avalere Health report—*Tracking Gaps in State Specialty Pharmacy Reimbursement*—highlights an interesting question: *Do new state Medicaid acquisition-cost pharmacy reimbursement models adequately compensate specialty pharmacies?*

The problem is easy to describe. State Medicaid programs are rapidly adopting acquisition cost methodologies for pharmacy reimbursement. These new models reduce or eliminate pharmacies' spread profits. Higher Medicaid dispensing fees are benchmarked to retail pharmacies and don't account for additional services provided for specialty drugs.

This situation, however, is hard to fix. Unless it is corrected soon, patients will be the big losers. Avalere implies that states will step up with higher fees. Instead, I suspect that manufacturers will be expected to pick up the tab as specialty pharmacies' spreads gets squeezed.

BUTTERING THE BREAD

A pharmacy typically earns the majority of its gross profits from spreads between third-party ingredient reimbursement and net acquisition costs. For specialty drugs, these spreads are about 5% to 10%, or $150 to $300 for a $3,000 brand-name specialty prescription.

As we discuss in Chapter 5 of the *2013-14 Economic Report on Retail, Mail, and Specialty Pharmacies*, state Medicaid programs are rapidly adopting average acquisition cost (AAC) methodologies. Six state Medicaid programs—Alabama, Colorado, Idaho, Iowa, Louisiana, and Oregon—rely on AAC data for pharmacy reimbursement. New York state recently launched its own AAC program.

The introduction of cost-based reimbursement models can benefit retail pharmacies. Spreads vanish (or shrink sharply) when ingredient cost reimbursement approximates actual drug acquisition costs. Compensation for prescription dispensing shifts from a spread-based model to a service-based model.

Consequently, state Medicaid programs have increased per-prescription dispensing fees to $9 to $15. Some states using AAC-based reimbursement use tiered dispensing fees based on a pharmacy's annual prescription volume or other factors.

SQUEEZING THE SPREAD

Alas, even the higher dispensing fees won't replace the substantial specialty pharmacy spreads. As the Avalere report rightly notes: "[E]ven states that have implemented an AAC-based reimbursement methodology have not differentiated dispensing fees for specialty/non-specialty drugs or for retail pharmacy/specialty pharmacy."

Specialty drugs in open distribution routinely show up in pharmacy acquisition cost surveys. Examples include such drugs as Avonex, Humira, Enbrel, and Neupogen. Based on the most recent data releases, all four drugs show up in the National Average Drug Acquisition Cost (NADAC) data file and the Alabama Medicaid Agency's AAC list.

Note that the NADAC data are based on 500 to 600 monthly surveys of retail community pharmacies. Specialty pharmacies are excluded from the NADAC surveys.

Here's another complication: State boards of pharmacy lack distinct regulatory requirements that define a "specialty pharmacy." As I note in The Explosion in Accredited Specialty Pharmacies, any pharmacy can designate itself a "specialty pharmacy" if its business focus is self-administered specialty pharmaceuticals covered under a patient's pharmacy insurance benefit.

Nonetheless, 66% of Medicaid programs claim to mandate the use of specialty pharmacies for the dispensing of self-administered specialty drugs. (See EMD Serono Survey, 9th edition, page 52.)

I CAN'T BELIEVE IT'S NOT PROFITABLE!

So, who will bear the burden of these reduced reimbursements?

Unfortunately, patients will suffer the most. In addition to basic product dispensing, patients taking specialty medications require services beyond those for traditional drugs. Specialty pharmacies will be caught between declining profit spreads and the patient care costs of higher services. Business survival will translate into reduced services for Medicaid patients.

The Avalere report focuses on blood plasma products, presumably because the report was funded by Grifols (a leading manufacturer of blood plasma products). Perhaps that's why Avalere optimistically writes: "State Medicaid programs may also consider establishing a separate dispensing fee that appropriately accounts for the services associated with the delivery of specialty drugs."

As I see it, it's more likely that manufacturers will be expected (or compelled?) to pick up the tab for those Medicaid patient services, via higher fees for specialty pharmacies. Caveat venditor.

STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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MEMORANDUM

DATE: January 30, 2014

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

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

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

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

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

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

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

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

SCPD has the following observations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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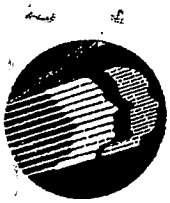

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

In re:
A G , a minor

DCIS No.:
5000703852

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

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

I

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

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

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

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

II

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

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

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

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

This is the decision resulting from that hearing.

III

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

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

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

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

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[2] 29 **Del. C.** §§ 7932-7935.

[3] Section 17300 DSSM.

Section 18000 DSSM.

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

youngster who receives medical assistance under the DSS Disabled

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

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

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

IV

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

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

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

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

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

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

[8] 20 U.S.C. §1400 et seq.

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

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

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

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

HEARING OFFICER

JUNE 22 2000
DATE

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

JUN 22 2000
POSTED

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

DOCUMENTS FILED IN OR FOR THE PROCEEDING

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

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

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

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

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

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

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

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

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

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

National Health Law Program
Sarah Somers
May 2006

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

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

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

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

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

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

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

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

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

EXCERPT

HHS Policy Clarification

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

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

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

Overview

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

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

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

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

A. The Part B Program

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

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

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

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

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

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

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

B. The Medicaid Program

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

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

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

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

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

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

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

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

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

C. Questions Addressed By The Handbook

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

Questions and Answers

A. Idea Policy Regarding Medicaid Billing

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

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

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

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

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

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

B. Medicaid Policy Regarding Payment For Health-Related Services

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

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

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

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

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

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

Authenticated PDF Version

2100 Eligibility Criteria

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

1.1 citizen or a lawful alien of the United States;

1.2 a resident of the State of Delaware;

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

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

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

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

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

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

1.4 significant limitations in adaptive behavior functioning;

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

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

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

1.5 the disability originates before age 22;

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

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

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

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

Last Updated: May 09 2013 14:00:03.

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

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

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

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

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

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

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

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

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

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

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

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EXCERPT

6.1.2.2 Securing and maintaining a checking account to be used for payroll related items

6.1.2.3 Filing and maintenance of payroll records required for payroll and tax preparation, as related to attendant employees

6.1.2.4 Discussing appropriate employee/employer relationships, including those cases where the employee is also a relative

6.2 The participant will:

6.2.1 Be responsible for all employment functions of the attendant including, but not limited to:

6.2.1.1 Conduct hiring interviews for attendants.

6.2.1.2 Supervise and direct attendant in job functions

6.2.1.3 Secure and maintain a checking account to be used for payroll related items

6.2.1.4 Maintain acceptable documentation for payroll and tax filing

6.2.1.5 Complete payroll related tax preparation and filings in a timely manner

6.2.2 Participant may accept or reject attendants referred to them by a provider agency

6.2.2.1 In the event the provider is unable to supply attendant(s) that are acceptable to a participant, the participant may be offered technical assistance to assess the participant's rationale for rejecting all attendant(s) and/or be referred to another provider agency.

6.2.2.2 Participants are provided the option of hiring a relative or spouse as their paid attendant. A relative, including spouse is considered a paid employee and therefore subject to the same requirements as employees referred by the agency. Individual withholding and tax filing for relatives employees must be performed in compliance with current Federal and State Payroll laws.

6.3 Employees must be age 18 or above

6.3.1 The hiring of a minor may be considered on a case-by-case basis and prior approval by DSAAPD is required.

6.3.1.1 The employment of a minor employee is subject to Child Labor Laws and related rules and policies.

6.3.1.2 *Care must be exercised if service is provided by a minor, as they are limited to hours and times they are permitted to work, as outlined in Child Labor Laws and related rules and policies.*

6.4 Participants and the provider agency shall share in the responsibility for obtaining attendants when service hours become difficult to fill.

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

6.6 Additional short term attendant service hours may be authorized for participants if determined eligible by the DSAAPD Case Manager, and if funding permits

45 CFR 261.15 - CAN A FAMILY BE PENALIZED IF A PARENT REFUSES TO WORK BECAUSE HE OR SHE CANNOT FIND CHILD CARE?

§ 261.15 Can a family be penalized if a parent refuses to work because he or she cannot find child care?

(a) No, the State may not reduce or terminate assistance based on an individual's refusal to engage in required work if the individual is a single custodial parent caring for a child under age six who has a demonstrated inability to obtain needed child care, as specified at § 261.56.

(b) A State that fails to comply with the penalty exception at section 407(e)(2) of the Act and the requirements at § 261.56 may be subject to the State penalty specified at § 261.57.

45 CFR 261.56 - WHAT HAPPENS IF A PARENT CANNOT OBTAIN NEEDED CHILD CARE?

PREV | NEXT

CFR Updates Authorities (U.S. Code)

§ 261.56 What happens if a parent cannot obtain needed child care?

(a)

(1) If the individual is a single custodial parent caring for a child under age six, the State may not reduce or terminate assistance based on the parent's refusal to engage in required work if he or she demonstrates an inability to obtain needed child care for one or more of the following reasons:

(i) Appropriate child care within a reasonable distance from the home or work site is unavailable;

(ii) Informal child care by a relative or under other arrangements is unavailable or unsuitable; or

(iii) Appropriate and affordable formal child care arrangements are unavailable.

(2) Refusal to work when an acceptable form of child care is available is not protected from sanctioning.

(b)

(1) The State will determine when the individual has demonstrated that he or she cannot find child care, in accordance with criteria established by the State.

(2) These criteria must:

(i) Address the procedures that the State uses to determine if the parent has a demonstrated inability to obtain needed child care;

(ii) Include definitions of the terms "appropriate child care," "reasonable distance," "unsuitability of informal care," and "affordable child care arrangements"; and

(iii) Be submitted to us.

(c) The TANF agency must inform parents about:

(1) The penalty exception to the TANF work requirement, including the criteria and applicable definitions for determining whether an individual has demonstrated an inability to obtain needed child care;

(2) The State's process or procedures (including definitions) for determining a family's inability to obtain needed child care, and any other requirements or procedures, such as fair hearings, associated with this provision; and

(3) The fact that the exception does not extend the time limit for receiving Federal assistance.

[64 FR 17884, Apr. 12, 1999; 64 FR 40291, July 26, 1999]

An education rule that defies plain old common sense

DELAWARE VOICE
REP. JOHN KOWALKO & REP. KIM WILLIAMS

In late December, two very thoughtful opinion pieces appeared in Delaware newspapers concerning our current system for measuring educator effectiveness. We, as elected officials, believe it is important to take note not only of who authored these articles but of what they said in them.

On Dec. 18, the Delaware State News published a letter to the editor from G. Scott Reihm, Executive Director of the Delaware Association of School Administrators, titled "Teachers need support, not criticism." In this letter, Mr. Reihm and his membership publicly questioned the purpose of teacher evaluations – teacher improvement or to make difficult decisions about teacher employment?

Their confusion stemmed from comments made by Christopher Ruszkowski, chief officer of the Teacher Leader Effectiveness Unit at the Delaware Department of Education. When asked about the fact that a recent DOE report indicated that 99 percent of teachers evaluated in the 2012-13 school year were rated "effective" or "highly effective," Mr. Ruszkowski commented that "there seems to be a problem of either will or skill that's happening at our schools in which principals are not willing to look at the data in front of them and make some really difficult decisions." More telling than Mr. Ruszkowski's response is another fact revealed in a survey released by DOE in June of 2013: 96 percent of administrators, 87 percent of specialists, and 86 percent of teachers felt the current system needs improvement.

These are eye-popping numbers, especially since the end result of the system was to produce "effective" or "highly effective" ratings. Why would educators want to change a system that tells them they are doing well? This seems to defy both logic and common sense.

For the answer to this question, you need only turn to the opinion piece which appeared in The News Journal on Dec. 20, written by Mr. Reihm and Frederika Jenner, President of the Delaware State Education Association. Mr. Reihm and Ms. Jenner stated that their respective organizations "support an educator evaluation system that includes the concepts of professional growth, continuous improvement, and quality assurance." They noted that such a system "should hold educators and administrators accountable for student growth, but only within areas that they control." They assert that the system "must embody principles of fairness, reliability, transparency, and common sense."

It is hard to imagine how anyone who values education could quarrel with these statements.

They then let us in on a dirty little secret, one not shared by Mr. Ruszkowski, which was that "the State has implemented a system and developed measures which do not let administrators and teachers clearly know what is required of them. The system does not provide a complete picture of teacher performance. It uses tests that are not valid and reliable measures of teacher effectiveness, but rather snapshots of student performance on the day they are given." Perhaps this is why DOE wants to change a system that produces positive results.

Finally, on the heels of these two articles, came an opinion piece in the Jan. 21 edition of The News Journal titled "Children are more than just numbers on some chart," by Dr. Mervin Daugherty, Superintendent of the Red Clay Consolidated School District and President of the Delaware School Chief Officers Association. Dr. Daugherty called for an end to "nonsensical criticism from those who have never stepped foot into one of our buildings, walked into a classroom or volunteered to work with students after school." He noted it was time to work together and to continue our attempt to overcome the challenges students face and to work toward reaching the goals we set for every child.

As elected officials, we don't take these comments lightly, especially when they come from three well-respected and dedicated individuals – Dr. Daugherty, Ms. Jenner and Mr. Reihm. Instead, we pay attention to what they said and what it implores us to do. We must take the time to look into their concerns, see if they are valid and, if so, fix them. We need to insure that the system serves its intended purpose – to responsibly evaluate educators, hold them accountable for what they can directly influence and, most importantly, provide all our students with the skills and knowledge they need to be successful in life.

We call on the administration, the Department of Education and our colleagues in the General Assembly to join us in this effort. We stand ready to take whatever steps are necessary to ensure we get it done right. Our students and educators deserve no less.

State Rep. John Kowalko represents the 25th House District and Rep. Kim Williams represents the 19th House District. This statement was also signed by Sen. Bryan Townsend, Rep. Ed Osienski and Rep. Paul Baumbach, Rep. Charles Potter and Rep. Stephanie Bolden.

Susan D. Leath, President and Publisher
David F. Ledford, Executive Editor
John Sweeney, Editorial Page Editor

QUOTE OF THE DAY
"When Kamala suddenly gets powers that give her the opportunity to be just like her idol, Captain Marvel, it challenges the very core of her conservative values." **MARVEL COMICS,** description of its new superhero, a 16-year-old Muslim teenager

OUR VIEW

Solving the disconnect at schools

Once it's been established that a staff of teachers has shown credible progress in doing their job, then it seems obvious their students benefited as well. However, that's no certain reality considering the results of the revised educator evaluation, the Delaware Performance Assessment System (DPAS-II).

TEACHERS, STUDENTS

Overwhelmingly, Delaware teachers "aced" the test designed to rate their instructional effectiveness – only 1 percent of teachers scored "ineffective." Some 51 percent were rated "highly effective" and 48 percent were rated "satisfactory." However, their daily audience – the state's students – are not witnessing the same success, and the unfortunate proof is in their critical standardized test scores.

So what gives? The answer involves multiple factors. Among them, external classroom forces that interfere with the learning process – a reality that even the best of instructors can't compete with when it comes to producing students capable of academic rigor. For example, the data on high-poverty children's outcomes is sourced by harrowing realities at home that affect the classroom – among them disaffected parents.

Emotional and development delays defined as "special needs" students require medication that might interfere with a student's ability to grasp core subject matter because he becomes too sleepy or has difficulty focusing. Add to that poor diets and a lack of vital at-home resources, such as computers, to boost his competitiveness with other classmates.

Given these circumstances, such schools qualify for the federal government's Title I program that provides free breakfast and lunches that comply with standard healthy dietary recommendations. Others use parent engagement experts to navigate them through the maze of testing dates and provide free afterschool instructional help.

But there's another factor and it's tied to mandatory fiscal statewide cuts that single out classroom paraprofessionals as nonessential employees. Chat with teachers in overcrowded classrooms, or with large margins of high-need students. For them, these workers become a lifeline to assuring that a variety of students' needs, based on different levels of competency, are addressed. Paraprofessionals scheduled to lose their jobs in the Brandywine School District last spring were mainly early reading interventionists – they are the ones who keep students on track for literacy targets and computer lab facilitators, and administer the state's standardized tests.

Many outsiders consider them just classroom helpers, but reality supports the value of "paras" in making a difference in a failing student's consistent progress and that school's higher standardized tests results.

EDUCATION

Teacher evals disputed

State says principals need to be tougher

By Matthew Albright
The News Journal

Only 1 percent of Delaware teachers were rated ineffective during the first full year of the state's evaluation system, according to new Department of Education figures.

State officials say that shows school leaders aren't making the tough evaluations needed to give honest feedback and weed out low-performing teachers.

"Going forward, we need to ensure that school leaders implement the system well, so that our overall results reflect the reality of what's happening in our classrooms," said Secretary of Education Mark Murphy. "When only one in five of our students is graduating high school ready for their next step, we still have a long way to go."

Principals, who make most of the evaluations, say they were hesitant to give teachers low ratings based on a big, brand-new system many still were learning and some don't think is fair.

Though there's disagreement on how best to go about it, teacher evaluations are regarded widely as an important part of improving schools.

Mark Murphy

Many teachers are keenly interested in their scores, because good evaluations can qualify them for bonuses and career advancement, while bad ones can put them under scrutiny and even put their jobs in jeopardy.

The new five-part DPAS II evaluation system rolled out for the first time statewide last year. Teachers can be rated "exceeds expectations," "satisfactory" or "unsatisfactory."

Overall, more than half of teachers

See TEACHER, Page B3

Teacher: Evaluation system's debut rocky

Continued from Page B1

were marked "exceeds expectations," and just under half were marked "satisfactory." That left only 1 percent who were "unsatisfactory."

The data show almost no teachers received low marks on the first four parts of the evaluation, which judge professional responsibilities and rely on things like classroom observations.

But more teachers are struggling on a fifth component, which sets goals for each individual student to grow their test scores and judges teachers based on how many students meet those goals. Delaware's federal Race to the Top program requires teacher evaluations to include student growth.

When the state set goals for math and reading teachers whose students take the DCAS test, for example, a total of 17 percent of teachers earned unsatisfactory ratings, though most of them were within a range that allowed their bosses some leeway to upgrade them.

Component five is easily the most controversial part of the new system because it ties teachers' performance to student test scores. Critics argue many factors outside teachers' control can affect those scores, so that connection is unfair.

Merv Daugherty

The figures also show principals and other school leaders overwhelmingly used flexibility the system allows them to give teachers the benefit of the doubt.

Frederika Jenner

"I think people were very cautious throughout the state on this evaluation," said Merv Daugherty, superintendent of the Red Clay school district and head of the school chiefs association. "This is the first year this was implemented, and there were a lot of technical points that had to be worked out. We were building the plane while we were in the air."

For example: If a teacher faces a "split decision," earning an unsatisfactory on one part of the evaluation and a satisfactory on another, principals referee the overall grade.

When that happened, principals chose to pick the higher label 87 percent of the time.

"We want to avoid tying our principals' hands and making these decisions at the state level," Murphy said. "But we are expecting our school leaders to make the tough decisions to make sure our teachers are performing at their highest potential."

Many school leaders say they tended to give their teachers the benefit of the doubt because they were skittish about making potentially career-altering decisions based on a complicated new system they were still working to master.

Frederika Jenner, president of the Delaware State Education Association, said her group received many reports of technical glitches that complicated the evaluations.

"Last year's rollout was really challenging in a lot of ways," Jenner said. "You would expect there to be challenges of something that size, but it would probably be described as rocky at best."

Jenner said the state needs to be sure principals and teachers are getting more and better training on how to set good goals, how to do more accurate and thorough observations and how to navigate the evaluation system, among other training.

"This report indicates to me that you better show your teachers how to improve their practice," she said. "Otherwise, this doesn't work."

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YOUR OPINION

Tell us what you think at **delaware online.com**

How should teachers be evaluated?

YESTERDAY'S POLL RESULTS, B1

SURVEYING TEACHERS

Rating marks 'erosion'

Changes urged in state evaluation process

By Matthew Albright
The News Journal

Growing numbers of Delaware teachers are dissatisfied with the state assessment used to judge their performance, results from a statewide survey show.

"There is an erosion in the confidence teachers have," said Delaware Education Association President Frederika Jenner.

Christopher Ruszkowsi, head of teacher and leader effectiveness for the Department of Education, says state officials are listening and working to allay teachers' concerns.

"We ask our teachers and leaders every day to embrace feedback and look at data, so that's exactly what we're going to do ourselves," Ruszkowski said. "We believe in empowering teachers, and that's why we do this survey."

Each year the department commissions a survey to gather teachers' opinions on the assessment called the Delaware Performance Appraisal System II.

Frederika Jenner

DPAS comprises five components used to evaluate a teacher's performance. It was implemented statewide in 2008 after pilot programs.

Based on DPAS results, a teacher can earn a "highly effective," "effective" or "ineffective" rating,

See SURVEY, Page B2

EMERGING PREDATOR

Survey: Teachers say some parts aren't so fine

Continued from Page B1

which can affect pay and job security, among other things.

DOE will present the findings of the latest survey to the State Board of Education on Thursday during a meeting that will be open to public comment.

Respondents gave the system an average grade of "C," the lowest rating since the assessment began.

Three quarters of the surveyed teachers did not think the system should continue in its current form. More than 80 percent of administrators thought the same thing.

Jenner said several things have caused the survey results to sag. First are technical glitches – she said many teachers encountered problems last fall such as computer crashes and information arriving late.

"The rollout of some of these measures in the fall was slow, it was delayed, and it was problematic," she said. "Some people didn't have access to it until the fall."

Jenner said the state might be able to reverse the declining confidence by working out those kinks this school year. "If the roll-out goes better over the next three months, I think that would go a long way," she said.

Ruszkowsi said the state has learned from some of the hiccups.

"Unfortunately, the operational side of something this big can be more complicated than the theory behind it," he said. "We're committed to making sure it works for everybody."

Jenner also pointed to a controversial part of the evaluation designed to measure student growth, called "Component Five."

This component uses statistical measures to set

Respondents gave the system an average grade of "C," the lowest rating since the assessment began.

a score on end-of-course exams each student is expected to meet. Teachers are judged on the number of students in their class who meet those targets. The past year was the first in which all school personnel were judged under Component Five.

State officials say Component Five is only one of the measures to determine a teacher's performance. But many teachers say they can have success in all categories but the fifth and still get a poor evaluation.

State officials say the statistical measures give teachers realistic targets, and argue teachers should be expected to improve students scores.

But many teachers worry the measures don't account for factors like a student's family situation, disruptive classmates and other things they can't control but which can drag down test scores.

The survey suggests confidence in Component Five among teachers is shrinking: About 41 percent of the respondents thought the measure was "a good indicator of performance," down from 60 percent in the 2009-2010 school year.

"Based on comments during interviews, the general consensus is that the Student Improvement component is high stakes and because of that, it needs to be more fair to teachers, specialists and special education students," a summary of the survey said.

Ruszkowski said the state has to walk a balance between assessments that teachers believe in and real accountability.

"We built this system around feedback for our teachers," he said. "But there also has to be a place for a summative judgment, where the principal takes a really hard look at what you're doing in the classroom and how your students are growing."

Respondents also complained of problems with communication regarding exactly how they would be judged and with the volume of paperwork required to complete an evaluation, among other concerns.

Majorities of teachers said they didn't think communications from the Department of Education had been clear, valuable and timely.

"From the conversations I've had, the communication regarding the entire evaluation is too infrequent and not clear enough," Jenner said.

"That's complicated by the fact that often the information doesn't come directly to the teacher – it comes from the state to the superintendent to the principal and then finally to the teachers," she said.

The survey shows teachers have higher opinions of how their districts and individual schools are assessing them than the state.

Teachers do seem to be happy with some parts of the assessment process. More than 80 percent say they receive adequate feedback, while solid majorities say they think the component that measures instruction is effective.

Matthew Albright can be reached at 324-2428 or malbright@delawareonline.com.

§ 231 Definitions relating to state of mind.

(a) *"Criminal negligence"*. — A person acts with criminal negligence with respect to an element of an offense when the person fails to perceive a risk that the element exists or will result from the conduct. The risk must be of such a nature and degree that failure to perceive it constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation.

(b) *"Intentionally"*. — A person acts intentionally with respect to an element of an offense when:

(1) If the element involves the nature of the person's conduct or a result thereof, it is the person's conscious object to engage in conduct of that nature or to cause that result; and

(2) If the element involves the attendant circumstances, the person is aware of the existence of such circumstances or believes or hopes that they exist.

(c) *"Knowingly"*. — A person acts knowingly with respect to an element of an offense when:

(1) If the element involves the nature of the person's conduct or the attendant circumstances, the person is aware that the conduct is of that nature or that such circumstances exist; and

(2) If the element involves a result of the person's conduct, the person is aware that it is practically certain that the conduct will cause that result.

(d) *"Negligence"*. — A person acts with negligence with respect to an element of an offense when the person fails to exercise the standard of care which a reasonable person would observe in the situation.

(e) *"Recklessly"*. — A person acts recklessly with respect to an element of an offense when the person is aware of and consciously disregards a substantial and unjustifiable risk that the element exists or will result from the conduct. The risk must be of such a nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation. A person who creates such a risk but is unaware thereof solely by reason of voluntary intoxication also acts recklessly with respect thereto.

11 Del. C. 1953, § 231; 58 Del. Laws, c. 497, § 1; 63 Del. Laws, c. 88, § 6; 70 Del. Laws, c. 186, § 1.;

§ 255 Knowledge of high probability.

When knowledge of the existence of a particular fact is an element of an offense, such knowledge is established if a person is aware of a high probability of its existence, unless the person actually believes that it does not exist.

11 Del. C. 1953, § 255; 58 Del. Laws, c. 497, § 1; 70 Del. Laws, c. 186, § 1.;

§ 4177K Revocation of license for persons convicted of all drug offenses.

(a) Except as provided by § 1012 of Title 10, any person who pleads guilty to or is convicted of, including a guilty plea or conviction pursuant to § 4767 of Title 16, a violation of §§ 4752-4764 of Title 16, or any drug offense under Chapter 5 of Title 11 or under any law of the United States, any state of the United States or any local jurisdiction or the District of Columbia, or who is adjudicated delinquent as a result of acts which would constitute such offenses if committed by an adult, shall, in addition to any and all other penalties provided by law, have the person's driver's license and/or driving privileges revoked by the Secretary for a period of 6 months from the date of sentencing.

(b) In cases where this section is applied, the Court shall immediately take possession of any Delaware issued driver's license and forthwith forward it to the Secretary, together with notification that revocation pursuant to this section has been implemented.

(c) When a driver's license is revoked pursuant to this section, any such individual not in violation of probational requirements regarding substance abuse treatment shall be permitted to apply for a conditional license for the limited purpose of employment, to attend treatment appointments and to meet with their probation officer.

(d) [Transferred to paragraph (c) of this section].

(e) [Repealed].

67 Del. Laws, c. 148, § 1; 67 Del. Laws, c. 429, §§ 6-8; 69 Del. Laws, c. 125, §§ 3, 4; 69 Del. Laws, c. 190, § 2; 70 Del. Laws, c. 186, § 1; 73 Del. Laws, c. 408, § 2; 73 Del. Laws, c. 414, § 2; 74 Del. Laws, c. 273, § 2; 76 Del. Laws, c. 94, §§ 1, 2; 78 Del. Laws, c. 12, § 70.

EXCERPT: STATE OF THE STATE ADDRESS (JANUARY, 2014)

The Opportunity to Contribute

We cannot meet the potential of our great state and our great country if we give up on a great number of our people. Today, America incarcerates more than 2 million people, and each year we release more than 700,000 inmates. 25 years ago, the total number of people incarcerated was 700,000.

For released inmates, their criminal record makes it difficult to be productive members of society.

There are those who belong behind bars and it is worth every penny we spend to keep them there. But when a person has served their time, it's up to them – and to us – to make sure they transition effectively, achieve their potential and contribute to society.

In 2009, with the leadership of Secretary McMahon and Director Ben Addi, we began our I-ADAPT initiative to help offenders prepare for their eventual release by giving them some of what they need to return to our communities. Identification. Access to medical care. A transition plan. Job training opportunities.

Five years of experience has taught us that those little things make a big difference. But for many offenders there is one thing we can't give them – a driver's license. Many offenders guilty of drug offenses are denied a driver's license – regardless of whether their crime had anything to do with a car. This penalty is just one more punishment that prevents them from seeking employment and accessing job training.

This should change. I ask you to eliminate the arbitrary loss of a drivers' license for crimes that have nothing to do with automobiles.

Too many of the inmates we release end up going back to prison. One of the best predictors of whether a person will commit another crime is whether they have a job. If we know employing ex-offenders helps make our communities safer, why are we putting so many hurdles in the way of job opportunities for ex-offenders?

We need to start by looking at employment discrimination against people who have repaid their debt to society. Here is an example: If there is one employer in Delaware that should be able to decide whether hiring an ex-offender makes sense, it's the Department of Correction. But the Department is prohibited from hiring anyone with a felony record, even on a part-time basis.

As Representative JJ Johnson has suggested, we can do better.

Many communities have started to "ban the box" on job applications by eliminating the box that says "check here if you've been convicted of a crime." I believe we should ban the box for state government hires this year.

Let's stop denying ex-offenders their first interview. Let's be a model for the private sector, because marginalizing ex-offenders helps none of us.

Delaware's incarceration rate is higher than the national average in a country whose average is higher than the rest of the world's. That's not a point of pride, it's incredibly expensive, and it hasn't worked.

We lock up too many people for not making bail and not appearing at hearings. Forty percent of the women incarcerated at Baylor are pre-trial detainees, many charged with non-violent offenses.

TASC is sponsored by the Administration on Intellectual and Developmental Disabilities (AIDD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Rehabilitation Services Administration (RSA), the Social Security Administration (SSA), and the Health Resources Services Administration (HRSA). TASC is a division of the National Disability Rights Network (NDRN).

FACT SHEET

The Value and Role of Work During Recovery From Mental Illness

By Aaron Kingson and Cathy Costanzo

Center for Public Representation

January 2014

I. Introduction

Among adults living with mental illness, the unemployment rate is three to five times higher than the general population (National Alliance on Mental Health, 2010). Yet most individuals with mental illnesses want to work (Provencher, Gregg, Mead, & Mueser, 2002). Additionally, research studies show that even individuals with serious mental illness have the ability to successfully work, even after extended work interruptions (Russinova, Bloch, & Lyass, 2007), and that competitive employment has proven to be valuable to the mental illness recovery process.[1]

This Fact Sheet (1) provides information on evidence-based practice regarding work and its role in recovery; (2) reviews the literature to identify principles of supported employment that help facilitate positive employment experiences for individuals in recovery and reentry to work and community; and (3) seeks to inform and reinforce the practice and advocacy of Protection and Advocacy systems (P&As).

Definitions for 'work' and 'recovery' vary greatly across stakeholder groups. The definitions used in this paper are adapted primarily from federal legislation and emphasize inclusiveness and the importance of work in the recovery process. As used in this report:

- "Work" is competitive and enables the individual to earn at least minimum wage in an integrated work setting.[2] This definition of work does not include sheltered

[1] This Fact Sheet does not attempt to address the issue of whether competitive employment is appropriate for all individuals recovering from mental illness at every stage of recovery.

[2] The definition of work included in the Rehabilitation Act 7(35) – Supported Employment (Office of Law Revision Counsel of the House of Representatives, 2001, p. 4389) is as follows:

or other non-integrated or non-competitive employment;

- "Recovery" is holistic, focused on self-direction, and stresses the connections between recovery, work, and psychiatric rehabilitation;[3] and
- "Supported employment," is defined by the Centers for Medicare and Medicaid Services (CMS), as "assistance in obtaining and keeping competitive employment in an integrated setting."[4] .

The sections below provide background on federal legislation and current programs, examine the value of work and access to work opportunities, suggest best practices, and explore policy ideas that incorporate best practices. The final section proposes ways that P&As may advance supported employment for clients in recovery from mental illness.

(i) Competitive employment in integrated work settings; or
(ii) Employment in integrated work settings in which individuals are working toward competitive work; and,
(iii) Is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals.

[3] The Substance Abuse and Mental Health Services Administration (SAMHSA) delineates the new working definition of recovery as:
(i) The process of psychiatric rehabilitation "through which individuals improve their health and wellness,
(ii) live a self directed life; and
(iii) strive to reach their full potential. (2011, p.1)

For the purpose of this paper, work during recovery is further defined from language in the definition included in the Rehabilitation Act 7(35) – Supported Employment (Office of Law Revision Counsel of the House of Representatives, 2001, p. 4389):
"(ii) for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability..."

The following definition of "psychiatric rehabilitation" was adopted by the US Psychiatric Rehabilitation Board in 2007:

> Psychiatric Rehabilitation promotes recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

[4] For definition and other CMS initiatives that promote employment, please visit: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html.

II. Background

Over the last 40 years, federal legislation, initiatives and appropriations have supported the choice of individuals in recovery from work-disrupting mental illnesses to work by mitigating traditional barriers including discrimination, loss of benefits, and inflexible work environments. Federal legislation seeking to remove many barriers to work and/or encourage employment includes:

- 1973 - Section 504 of the Rehabilitation Act of 1973, the first legislative breakthrough, makes it illegal for public entities and those receiving federal funding to discriminate against individuals with disabilities.
- 1986 - The Rehabilitation Act Amendments of 1986 includes supported employment to assist persons with the most significant disabilities to achieve and retain competitive employment.
- 1990 – The Americans with Disabilities Act makes it illegal for any employer to discriminate or directly harass on the basis of disability. The Act requires reasonable accommodations for the disability unless doing so causes undue hardship to the employer. Title II of the ADA requires that governmental services, including employment programs, not discriminate.
- 1992 - The Rehabilitation Act Amendments of 1992 mandated that individual rehabilitation plans for adults with disabilities are co-developed with the consumer. The amendments also required Centers for Independent Living to deliver consumer-directed services that represent different disability groups (*e.g.* not just individuals with physical disabilities) (Shreve, n.d.).
- 1998 - The Workforce Investment Act was designed to provide occupational training and education to develop the nation's workforce. This included the creation of centers to help people with disabilities access programs to enhance their ability to gain or retain jobs.
- 1999 - The Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA) protects medical benefits for some recipients of Medicare and Medicaid when they return to work (Timeline, n.d.).
- 2000 – Executive Order 13163 was supposed to increase by 100,000 persons the number of individuals with disabilities employed in the federal workforce, but few steps were taken and little progress was made. 65 Fed. Reg. 46563 (Executive Office of the President, 2000).
- 2010 - Executive Order 13548 -- Increasing Federal Employment of Individuals with Disabilities, delineates specific steps to achieve the goals of Executive Order 13163. 76 Fed. Reg. 52845 (Executive Office of the President, 2011).
- 2011 - Affordable Care Act Provisions – Home and Community-Based Services 1915(i) allows states to cover Supported Employment and other "habilitation" services under this Medicaid waiver; and 1915(k) increases the federal match for this waiver by 6% (specific match percentages vary by state). To many

advocates, these provisions not only support employment, but also promote integrated community-based services over institutional programs (ADAPT, 2011).

The Office of Disability Employment Policy (ODEP), the Social Security Administration (SSA), and CMS have programs, policies and initiatives that encourage employment and support individuals who want to work. ODEP, housed within the United States Department of Labor, was established in 2001, in response to "the need for a national policy to ensure that people with disabilities are fully integrated into the 21st Century workforce..." (ODEP, n.d.). ODEP has many new and emerging policies to support employment and remove barriers to work.[5]

SSA Demonstration Projects

Recent SSA demonstration projects that assess interventions that encourage work for recipients include (1) the Mental Health Treatment Study, (2) the Accelerated Benefits Demonstration, and (3) the Benefit Offset National Demonstration. They are described in the following paragraphs.

From 2006 to 2010 the Mental Health Treatment Study (MHTS) demonstration project provided both supported employment and systematic medication management services to SSDI beneficiaries with serious mental illnesses. Over 2,000 beneficiaries were recruited and integrated services were provided at 23 sites throughout the country. The evaluation of this study found that the MHTS treatment group improved both employment and health outcomes (Frey, Drake, Bond, Miller, Goldman, Salkever ... Collins, 2011).

The Accelerated Benefits Demonstration included 2,000 participants across 53 metropolitan areas who were randomized into three groups in 2008. Two groups both received accelerated health care benefits at least 18 months before Medicare eligibility, and one of the two also received telephone services that promote work. The control group (the third group) received no accelerated benefits or telephone services. Initial one-year findings show that access to health care and health improvements are significant, but additional research is needed to determine impact on employment outcomes (Mann & Wittenburg, 2012).

In 2005, four states implemented a pilot to prepare for the Benefit Offset National Demonstration that is now in progress. Every state has now recruited between 250 and 600 participants who were randomly assigned to control or treatment groups. As an alternative to the standing policy of losing all financial benefits at sustained earnings levels of substantial gainful activity (SGA)[6], the treatment group's benefits are reduced

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[5] Current ODEP policies include the Inclusive Federal Contractor Requirements and Small Business Tax Credits (IRS Code Section 44, Disabled Access). Detailed descriptions of all of ODEP initiatives and policies may be found at http://www.dol.gov/odep/about/.

[6] In 2014, SGA for persons receiving Social Security Disability Insurance benefits is $1,070 per month for non-blind individuals and $1,800 for blind individuals (Social Security Administration, n.d.)

by $1 per $2 of additional earnings. Both the control and treatment groups are offered additional vocational counseling services. This project has not yet been evaluated (Mann & Wittenburg, 2012).

In addition to the Ticket to Work Act referenced above, CMS provides states with the option to offer Medicaid recipients supported employment services through Home and Community Based Services under the provisions of Section 1915(c)(5)(C) or 1915(i) waivers. These services, defined as "assistance in obtaining and keeping competitive employment in an integrated setting," and peer support services that deliver "counseling and other support services to Medicaid eligible adults with mental illnesses..." (CMS, n.d.), are more comprehensive than those available through federal-only Medicaid programs.

III. Value of work

There is a wide array of significant benefits to competitive employment during recovery. First-person accounts often cite the importance of work during recovery because it enhances connections with others, self-esteem, self-sufficiency, personal responsibility, stress management, and views of self-worth by contributing to society (Dunn, Wewiorski, & Rogers, 2008). People with a mental health diagnosis who work feel that they are more respected, are more financially independent, and have more meaningful relationships (McGurk, Mueser, DeRosa, & Wolfe, 2009).

In 2008, Dunn, et al., performed a qualitative study interviewing individuals with serious mental illness who have been successful working during recovery. The study, which included 23 interviews, concludes that 'significant benefits' are realized during the recovery process from work. One common theme among participants was the value of employment at promoting recovery through supporting confidence and self-pride. One study participant shared that "at (one) point I felt like work was the only thing in my life that had any value (p. 61)." Other themes were the importance of establishing daily routines through employment, distraction from negative thoughts, overcoming symptoms of isolation, and achieving financial self-sufficiency. Previous studies corroborate these results (Honey, 2004; Provencher et al. 2002).

A. Employment not only promotes recovery, but it has also been shown to decrease long-term service use and costs.

Bush, Drake, Xie, McHugo, and Haslett (2009) published a rigorous 10-year study of utilization and cost that followed 187 individuals in recovery. Minimum- and steady-work groups that controlled for education, work history, psychiatric diagnosis, and severity of psychopathology were compared and longitudinal patterns of work, utilization and cost outcomes were established. The conclusion of the study was that "highly significant reductions in service use were associated with steady employment." (p. 1024).[7]

[7] The literature cited in the paper also suggests that the significant benefits of work in recovery include the potential to combat depression, mend personal identity, develop and recover skills,

B. Competitive employment has been shown to benefit individuals with different recovery experiences.

According to a qualitative study by Provencher et al., individuals with different recovery experiences all realized benefits from work. People who viewed their recovery as uncertain benefitted from developing structure to fill free time, building secure environments, and having distractions from their worries; those who experienced recovery as self-empowering benefitted from regaining pride and connecting with others; those who felt recovery was challenging gained from feeling that they were meeting their potential. The study findings provided support for the theory that employment has positive effects on other aspects of recovery, such as creating a secure base, supportive relationships, and coping mechanisms (2002).

C. Working in an integrated setting influences every dimension of recovery.

Along with education and housing, one of three functional recovery factors defined by Whitley and Drake is employment, with "obtaining and maintaining employment" as the measurable outcome. And functional recovery is linked to the other four dimensions of recovery (clinical, existential, physical and social). For instance, "employment (functional recovery) may lead to inclusion in positive social networks (social recovery), which might enhance hope and responsibility (existential recovery). These factors may work together to reduce symptoms (clinical recovery)." (2010, p. 1250). Consumer movements often also focus on the participation in self-directed employment as a marker of recovery.

D. All of the literature promotes work.

In the entire literature review, not one negative effect of employment during recovery was mentioned. An academic search for "detrimental effects of employment during recovery from mental illness" and related topics and key words revealed that the only negative references pertained to barriers to employment including the impact of stigma, self-disclosure, and lost productivity from mental illness. All of these negative associations between employment and mental illness are unrelated to negative effects of work during recovery.

Marrone and Golowka performed an extensive literature search as well and found no clinical research studies regarding ill effects of employment on people with mental health disabilities. Rather, the authors stress that the benefits of employment far outweigh the stresses of employment on mental health. In addition, they noted the benefits of realizing a role other than "consumer," decreasing stress from being on public benefits, developing possibilities for romantic relationships, and increasing the meaning of leisure time (1999).

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expand social networks and support systems, decrease long-term reliance on benefits, better achieve long-term goals, and increase structure in ways that promote recovery.

IV. Supported Employment

In a qualitative study by Dunn et al. (2010), seven themes emerged as important to helping individuals in recovery return to work and stay employed. These themes are "having the confidence to work, having the motivation to work, possessing work-related skills, assessing person–job fit, creating work opportunities, receiving social support, and having access to consumer-oriented programs and services." (p. 185).

Evidence-based research indicates supported employment is the intervention that most effectively optimizes employment outcomes for individuals in recovery from mental illness who are returning to work. A 2012 SAMHSA training teleconference discusses Individual Placement and Support (IPS) Supported Employment as a "new" tool backed by decades of research.

This evidence-based practice model has five defining features:

- The approach leads to a mainstream job in the community.
- The job pays at least minimum wage.
- The work setting includes people who are not disabled.
- The service agency provides ongoing support.
- This type of employment is intended for people with the most severe disabilities.

"The Role of Employment in Recovery and Social Inclusion: An Integrated Approach" August 14, 2012 (available at www.promoteacceptance.samhsa.gov).

Supported employment differs from other models in that it: emphasizes choice, encourages rapid entry/reentry into the labor force over prevocational assessment and training programs; and provides supports and assistance to find and keep competitive jobs in the community (Center for Evidence-Based Practices, n.d.).

In 2008, Bond, Drake, and Becker summarized results from 11 studies in the employment outcome areas of "employment rates, days to first job, annualized weeks worked, and job tenure in the longest job held during the follow-up period." (p. 280). The conclusion was that the Individual Placement and Support Model for supported employment (IPS) had the best work outcomes as compared with other vocational rehabilitation models. Most significantly, the competitive employment rate for IPS was 61% vs. 23% for controls.

Additional research corroborates these findings. Bush, Drake, et al., researchers affiliated with the Dartmouth Psychiatric Research Center, a leading national center on mental health and employment policy, state that "a specific vocational intervention—supported employment— has been demonstrated over the past 20 years to be an evidence-based practice for persons with serious mental illnesses. Methodologically rigorous studies show that supported employment is nearly three times as effective as other interventions for helping persons with psychiatric disabilities to achieve

competitive employment, increases the number of hours worked, and accomplishes other vocational outcomes." (2009, p. 1024) Research by Bond and others show similar impacts, and sustained or increased long-term employment outcomes despite less reliance on vocational services. (Becker, Whitley, Bailey,& Drake, 2007; Bond, 2004; and Cook, Leff, Blyler, Gold, Goldberg, Mueser, ...Burke-Miller, 2005).

V. Best practices

A. Supported employment stands alone in the research as the best practice for supporting recovery through work for individuals with serious mental health conditions.

The following basic principles of Individual Placement and Supported Employment (IPSE) are advanced by the IPS Supported Employment Center at Dartmouth. They are similar to the principles delineated by McGurk et al. (2009, p. 5).

1. **Focus on Competitive Employment:** Agencies providing IPS services are committed to competitive employment as an attainable goal for clients with serious mental illness seeking employment.
2. **Eligibility Based on Client Choice:** Clients are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, level of disability, or legal system involvement.
3. **Integration of Rehabilitation and Mental Health Services:** IPS programs are closely integrated with mental health treatment teams.
4. **Attention to Client Preferences:** Services are based on clients' preferences and choices, rather than providers' judgments.
5. **Personalized Benefits Counseling:** Employment specialists help clients obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements.
6. **Rapid Job Search:** IPS programs use a rapid job search approach to help clients obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling.
7. **Systematic Job Development:** Employment specialists build an employer network based on clients' interests, developing relationships with local employers by making systematic contacts.
8. **Time-Unlimited and Individualized Support:** Follow-along supports are individualized and continued for as long as the client wants and needs the support.

Bond (2004) finds that evidence-based research shows the strongest support for principles one (competitive employment), two (client choice) and six (rapid job search). Rapid reentry into employment has also been shown to increase the probability of employment leading to a career rather than just planning for employment (Marrone &

Golowka, 1999; Bond et al. 1995). Bond goes on to discuss moderately strong evidence in support of principles three (integrating rehabilitation and mental health teams) and four (honoring client preferences).

Additional research supports principle three. In the SSA Mental Health Treatment Study discussed above in Section II, Frey, et al., found that this 2,238-participant demonstration project combining supported employment and systemic medication management services improved employment and health outcomes for treatment group members. At the end of the 24-month study, 61% of the treatment group was employed vs. 40% of the control group. However, average earnings for both groups were well below SGA ($251 per month) and not significantly different between the groups. Notably, hospitalizations and psychiatric treatment visits decreased in frequency and length for treatment group beneficiaries (Frey et al., 2011). A different study by McGurk et al. (2009) found that the combination of supported employment and cognitive remediation services enhanced employment outcomes and increased cognitive recovery more than supported employment alone.

B. In addition to the basic principles of IPSE, the ideal relationship between work and the recovery process based on our research might include the following provisions:

1. **Attainable intermediary outcomes:** *Taking client preferences into account, goals and outcomes should be realistic, incremental and flexible.* Defined goals, outcomes, and timetables for securing employment are critical to progress. Development and evaluation of progress markers should take into consideration that recovery is not always a linear process. For example, an individual may have excelled at a full-time position prior to a relapse of mental illness, but in early recovery this person may not be able to work full time or be competitive at the same level of employment prior to relapse. Rather, his goals may begin with satisfactorily holding a half-time entry level position that later leads to full employment in his previous field.

2. **Redefining success:** *Individualized client supports that define and celebrate every new vocational success as a milestone of recovery.* Throughout the recovery process and particularly in early recovery, every accomplishment is significant and often formative. Employment specialists should emphasize each new milestone that is crossed, and never take an achievement for granted. In early recovery, successes may include regular attendance, notifying the employer if absent, and passing probationary review; intermediate successes may include consistent attendance, increasing hours worked, and less reliance on benefits; and advanced successes may include a month of perfect attendance, securing a full-time position within the individual's previous field, and financial independence.

3. **The evolving personal value of work:** *Employment specialists and counseling services that emphasize the individual reasons to work and the progressing value of work.* As discussed in the 'Value of Work' section, not every person in recovery works for the same reasons or benefits from work in the same ways. The value derived

from work often changes as a person recovers. Supports that emphasize current reasons to work and benefits of employment, in addition to past successes attributable to work, best incentivize future employment. An individual may begin working for self-esteem and to establish daily routines. As self-esteem builds and routines become easier, he may continue to work to increase his personal responsibility and social circle. In later recovery, his value of work may build to include financial independence.

VI. Implications for P&As

The research is uncontroverted that competitive work throughout the recovery process is proven to be valuable to people needing mental health services, with no known disadvantages. Furthermore, employment is a critical factor not only in the recovery process but as an essential feature of integration into the community. It is imperative that the P&As advocate for strategies that promoting competitive employment opportunities and programs.

P&As should consider how they can advocate for the funding of Individual Placement and Supported Employment, and programs based on similar principles, which are shown to be the most effective evidence-based program interventions. At the state level, it is possible to address the importance of work in a number of ways. First, focus on the importance of work and supported employment in individual advocacy for individuals with mental illness. Second, advocate for the creation and expansion of supported employment services for individuals in the mental health system and promote increased awareness and the utilization of benefits counseling to understand how work incentives can be used to enhance opportunities for stable employment. P&As should also advocate for the inclusion of supported employment initiatives in Olmstead Plans. Finally, consider forming alliances with stakeholders, such as consumer groups, to devise strategies for promoting employment.

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Title 2 Transportation
Driver Services
Authenticated PDF Version

2210 Issuance of a Conditional License as the Result of a Suspension Due to a Conviction for Passing a Stopped School Bus. (Formerly Reg. No. 57)

1.0 Authority

The authority to promulgate this regulation is 21 **Del.C.** §302, 21 **Del.C.** §4177(j) and 29 **Del.C.** §10115.

2.0 Purpose

This policy regulation establishes administrative procedures regarding the issuance of a conditional license following a suspension action due to a conviction for passing a stopped school bus in violation of 21 **Del.C.** §4166(d).

3.0 Applicability

This policy regulation interprets the following sections found in 21 **Del.C.** §4166

4.0 Substance of Policy

4.1 Upon receiving a notice of conviction for a violation of 21 **Del.C.** §4166(d) the driver's license and/or driving privilege shall be suspended for a period of one (1) month for a first offense.

4.2 Upon receiving a notice of conviction for a second violation of 21 **Del.C.** §4166(d) within three (3) years of a prior violation, the driver's license and/or driving privilege shall be suspended for a period of six (6) months.

4.3 Upon receiving a notice of conviction for a third or further subsequent violation of 21 **Del.C.** §4166(d) within three (3) years of a prior violation, the driver's license and/or driving privilege shall be suspended for a period of one (1) year.

4.4 In the event of a suspension of a driver's license pursuant to this policy, the Division may issue a conditional license during the period of suspension if the applicant stipulates the suspension has created an extreme hardship, such as loss of meaningful employment opportunity or loss of school opportunity.

4.4.1 A minimum suspension period of one (1) month must be served without driving authority if the suspension action is processed based on (4.1) above.

4.4.2 A minimum suspension period of three (3) months must be served without driving authority if the suspension action is processed based on (4.2) above.

4.4.3 A minimum suspension period of six (6) months must be served without driving authority if the suspension action is processed based on (4.3) above.

4.5 However no such conditional license shall be issued if the licensee has been issued an occupational license or a conditional license within the preceding twelve (12) months or has previously been issued a total of three (3) occupational or conditional licenses as shown on the licensee's driving record.

4.6 The Department, upon receiving a record of conviction of any person upon a violation of operating a motor vehicle in violation of the condition imposed upon said conditional license during the period of such conditional license, shall immediately extend the period of such suspension for an additional like period and shall forthwith direct such person to surrender said conditional license to the Department.

5.0 Severability

If any part of this rule is held to be unconstitutional or otherwise contrary to law by a court of competent jurisdiction, said portion shall be severed and the remaining portions of this rule shall remain in full force and effect under Delaware law.

6.0 Effective Date

The following regulation shall be effective 10 days from the date the order is signed and it is published in its final form in the Register of Regulations in accordance with 29 **Del.C.** § 10118(e).

9 DE Reg. 1988 (06/01/06)

Last Updated: October 05 2010 16:16:16.

Title 2 Transportation
Driver Services

Authenticated PDF Version

2211 The Issuance of Restricted Driving Privileges as the Result of a Suspension or Revocation Order Received from Family Court Relative to a Juvenile Being in Violation of 21 Del.C. §4177. (Formerly Reg. No. 63)

1.0 Authority

The authority to promulgate this regulation is 21 **Del.C.** §302, 21 **Del.C.** §4177, 10 **Del.C.** §1009(f) and 29 **Del.C.** §10115.

2.0 Purpose

This policy regulation establishes administrative procedures regarding the issuance of restricted driving privileges following a suspension or revocation order received from Family court relative to a juvenile being in violation of 21 **Del.C.** §4177.

3.0 Applicability

This policy regulation interprets the following sections found in 21 **Del.C.** §4177, §4177B, and 10 **Del.C.** §1009(f).

4.0 Substance of Policy

4.1 Requests for restricted driving authority pertaining to employment must be accompanied by a notarized statement from the employer stating that no authority to drive would result in the loss of a meaningful employment opportunity.

4.2 Requests for restricted driving privileges pertaining to attending school must be accompanied by a notarized statement from an official of the school stating that without the authority to drive a loss of a school opportunity would result.

4.3 Requests for restricted driving privileges for any other urgent need of the individual must be accompanied by a notarized statement from a member of the immediate family stating that no member of the immediate family is capable of satisfying such urgent need.

5.0 Severability

If any part of this rule is held to be unconstitutional or otherwise contrary to law by a court of competent jurisdiction, said portion shall be severed and the remaining portions of this rule shall remain in full force and effect under Delaware law.

6.0 Effective Date

The following regulation shall be effective 10 days from the date the order is signed and it is published in its final form in the Register of Regulations in accordance with 29 **Del.C.** § 10118(e).

9 DE Reg. 1988 (06/01/06)

Last Updated: October 05 2010 16:16:16.

Title 2 Transportation
Driver Services

Authenticated PDF Version

2212 Issuance of Occupation Driver's License After Conviction of No Insurance on a Vehicle (Formerly Reg. No. 78

1.0 Authority

The authority to promulgate this regulation is 21 **Del.C.** §302, 21 **Del.C.** §2118, and 29 **Del.C.** §10115.

2.0 Purpose

This policy regulation establishes administrative procedures used to issue occupational driving authority following conviction of failure to have insurance or failure to display an insurance ID card.

3.0 Applicability

This policy regulation interprets the sections found in 21 **Del.C.** §2118(a) through (z) in their entirety.

4.0 Substance of Policy

In the event of a suspension of a driver's license pursuant to the provisions of 21 **Del. C.** Section 2118, the suspended person may be issued an Occupational License during the mandatory period of suspension. The applicant is eligible to apply provided:

4.1 The applicant was not involved in an accident at the time of the incident in which property damage or personal injury occurred

4.2 The applicant has not been issued an occupational license during the immediate past 12 months. (Not to include conditional licenses issued under 21 **Del.C.** §4177(E), §4177(K), or 16 **Del.C.** §4764 Drug Diversion.)

4.3 The applicant is not under suspension or revocation of his/her driving privileges for another reason at time of application that would preclude the issuance of driving authority.

4.4 All valid Delaware licenses are turned in to the Division.

4.5 The applicant states on the application that the loss of license would create an extreme hardship which shall be defined as:

4.5.1 Loss of meaningful employment opportunity;

4.5.2 Loss of a school opportunity; or

4.5.3 An urgent need by the applicant or within the family, which is critical to the family's health or welfare, and no other family members are capable of satisfying such urgent need. This includes; medical facilities, child, or adult care facilities.

4.6 An occupational license issued pursuant to this regulation shall reflect limited driving authority to drive for the above state reasons only. The occupational license shall be issued for the duration of the suspension period or the expiration of the license whichever is greater. The applicant may choose to renew the license prior to issuance of the occupational license or may complete the renewal process at a later time.

4.7 In order to apply for an occupational license, applicant must provide the following:

4.7.1 Employment

4.7.1.1 Proof of insurance on all vehicles registered in the name of the applicant and/or spouse, or the name of another, and/or on company-owned vehicles. (See Proof of Insurance).

4.7.1.2 If self employed, a copy of the applicant's business license must be provided and the copy remain on file with the application.

4.7.1.3 If driving vehicles owned by the employer, a statement from the employer stating:

4.7.1.3.1 Applicant is employed with the company.

4.7.1.3.2 Applicant's work days and hours.

4.7.1.3.3 If applicant needs to drive for employment-related duties.

4.7.1.3.4 Applicant will be driving company owned vehicles. (Please identify the vehicles).

4.7.1.3.5 If applicant will be driving a personal or other vehicle in addition to the company vehicle for these duties.

4.7.2 Attending School

4.7.2.1 Documentation on the application stating the name, address, and phone number of the facility.

4.7.2.1.1 Days and hours applicant is scheduled for classes; and

4.7.2.1.2 Loss of school opportunity if applicant is not granted authority to drive.

4.7.2.2 Proof of insurance on all vehicles registered in the name of the applicant and/or spouse, or the name of another, and/or on company-owned vehicles. (See Proof of Insurance)

4.7.3 Child or Adult Care Requests

4.7.3.1 Documentation on the application stating the name, address, and phone number of the facility.

4.7.3.2 Proof of insurance on all vehicles registered in the name of the applicant and/or spouse, or the name of another, and/or on company owned vehicles. (See Proof of Insurance)

4.7.4 Medical Requests

4.7.4.1 A statement on the application that no other means of transportation is available

4.7.4.2 Documentation on the application stating the name, address, and phone number of the physician or medical facility.

4.7.4.3 Proof of insurance on all vehicles registered in the name of the applicant and/or spouse, or the name of another, and/or on company-owned vehicles. (See Proof of Insurance)

4.7.5 Proof of Insurance

4.7.5.1 Privately-Owned Vehicles

4.7.5.1.1 Applicant's vehicles and/or vehicles where applicant's name is on the policy a valid insurance ID card must be shown.

4.7.5.1.2 Vehicle owned by the applicant's spouse and/or other vehicles personally owned by another individual must submit a valid insurance ID card.

4.7.5.2 Employers/Company-Owned Vehicles

4.7.5.2.1 Applicants requiring the privilege to drive their employer's vehicles for occupational purposes must present the employer's insurance ID or fleet ID card for proof of insurance.

4.7.5.2.2 If the business is privately owned and the insurance is issued under the employer's personal policy, the applicant must provide a valid insurance ID card.

4.7.6 Proof of Insurance that is not acceptable

4.7.6.1 Faxed copies of insurance documents unless faxed directly to the Division office

5.0 Severability

If any part of this rule is held to be unconstitutional or otherwise contrary to law by a court of competent jurisdiction, said portion shall be severed and the remaining portions of this rule shall remain in full force and effect under Delaware law.

6.0 Effective Date

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Last Updated: October 05 2010 16:16:16.

Delaware Senate lets Beau Biden's gun bill die

Written by Jonathan Starkey and Jon Offredo The News Journal
Jan. 14, 2014 10:42 PM | delawareonline.com

On lawmakers' first day back in Dover after a six-month break, the Delaware Senate blocked new debate on Attorney General Beau Biden's bill that would have attempted to keep firearms out of the hands of those considered dangerously mentally ill.

Biden, unable to muster enough support to bring the bill back for debate, did not make the trip to Legislative Hall Tuesday to persuade lawmakers to rescind a June 27 Senate vote that defeated the legislation after House lawmakers passed the bill in a 40-1 vote.

The legislation would have required mental health providers, in order to avoid legal liability, to call police if they believed a patient presented a danger to themselves or others. Police then would investigate the claim, and the Attorney General's office could petition a judge to force the patient to turn over guns in their possession.

Senate President Pro Tem Patricia Blevins, D-Elsmere, who supported the bill, said Democrats "weren't even close" to finding enough votes to bring the bill back for debate. The Senate's lack of action prevents the bill, in its current form, from passing the General Assembly. Biden had only three legislative days to persuade Senate lawmakers to bring the bill back to the floor for debate.

Senate Minority Leader Gary Simpson, R-Milford, said he expected Biden to be in Legislative Hall to make his case.

"If this bill is that important, I would think the attorney general would be present to debate it," Simpson said. "He should be on the job and seen and heard from, rather than his staff speaking in his name."

Biden's chief of staff, Timothy Mullaney, said Biden spent his day in meetings to discuss violence in Wilmington. Biden was not available for interviews to discuss a new Wilmington crime plan announced by Mayor Dennis Williams. Joe Rogalsky, who leads legislative efforts for Biden, said the attorney general would not give up on the gun-control issue.

"The attorney general believes this bill saves lives and it's too important of an issue to walk away from," Rogalsky said.

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GENERAL ASSEMBLY

Senate rejects gun bill

Beau Biden loses second bill in two days

By Jonathan Starkey
The News Journal

Attorney General Beau Biden suffered a stinging defeat Thursday on his final gun-control push in the state Senate, with just six senators backing a bill to force those with a dangerous mental illness to turn over their firearms.

The Senate also rejected, for the second time in two days, a proposed constitutional amendment backed by Biden that would have allowed judges to deny bail to any suspect charged with the most violent felonies. The bail amendment, which has failed in past sessions of the General Assembly, would have allowed a judge to deny bail for up to 90 days on the two highest classes of felonies, ranging from murder to burglary.

The firearm legislation, which earlier had passed the House overwhelmingly on a 40 to 1 vote, would have required mental health providers to call police if they suspected a patient presented a danger to themselves or others. The measure would have allowed police to investigate and submit a report to the Department of Justice. Justice Department attorneys would then have had the ability to petition a judge to compel the patient to turn over any firearms in his or her possession.

Beau Biden

After the 13-6 vote, Biden said the legislation was "directly responsive" to mass shootings around the country involving shooters with mental illnesses.

"I cannot explain what happened," Biden said. "This was just a common sense

See BIDEN, Page B2

Biden: Defeated in the Senate

Continued from Page B1

bill."

Dr. Neil Kaye, a Hockessin psychiatrist tapped by Biden's office for support, appeared to create some confusion on the Senate floor by saying the gun bill would only apply to those committed to an institution to receive treatment for a mental illness. The bill, in fact, applied to anyone believed to be dangerous by a mental health professional.

Senate Majority Leader David McBride, D-Hawk's Nest, was among those voting against the bill. Sen. Bryan Townsend, a Newark Democrat who did not cast a vote, said he heard concerns from constituents who worried the law would be applied inappropriately. Other senators said they received calls and emails Thursday morning in opposition to the bill. A National Rifle Association lobbyist said the gun advocacy group was neutral on the bill.

Biden and Gov. Jack Markell were the primary backers of other gun-control bills that did not clear the General Assembly this year, including a proposed ban on assault weapons, which was never debated, and a ban on high-capacity magazines that never reached the House floor.

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EXCERPT

Delaware House of Representatives
e-Newsletter
- A public service provided by the House Republican Caucus -
Issue 148 - January 18, 2014

NEWS:

Dead Gun Bill Gives Birth to New Measure

The Senate on Tuesday failed to reconsider a bill intended to prevent the mentally ill from possessing firearms, effectively killing the measure.

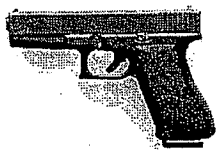
House Bill 88 had passed the House of Representatives last year on a vote of 40 to 1, but was later defeated in the Senate.

Proponents of the bill, including State Attorney General Beau Biden, were attempting to rally support to have the bill reconsidered in the Senate.


State Rep. Ruth Briggs King

Tuesday was the last day the legislation could have been recalled for another vote.

In the aftermath of that drama, two state lawmakers have re-introduced a minor provision of the failed bill that they believe needs to be enacted.



"My bill only addresses a narrow piece of House Bill 88 that had broad support," said Sen. Brian Pettyjohn, R-Georgetown, the prime sponsor of the legislation.

The Senate bill seeks to expand the crime of "possession and purchase of deadly weapons by persons prohibited." Under the proposal, the crime would include the perpetrators of violent crimes who have been found *not guilty by reason of insanity; guilty but mentally ill;* or *mentally incompetent to stand trial.*

"This bill says if you've gone through our criminal justice system, and you've been adjudicated as mentally ill or

mentally incompetent, then you are losing your right to possess a firearm," Sen. Pettyjohn said.

State Rep. Ruth Briggs King, R-Georgetown, the prime House sponsor of the bill, said the measure should improve public safety by keeping violators off the street longer and increasing the opportunity for those with known mental health issues to get the help they need.

The bill is currently being circulated for sponsorship and has not yet been introduced.