



# DISABILITIES LAW PROGRAM

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## MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory Initiatives

Date: October 6, 2015

Consistent with the requests of the SCPD and GACEC, I am providing an analysis of ten (10) regulatory initiatives in anticipation of the October 8 meeting. Given time constraints, the analysis should be considered preliminary and non-exhaustive.

### 1. DOE Final School Transportation Regulation [19 DE Reg. 307 (10/1/15)]

The SCPD and GACEC commented on the proposed version of this regulation in August, 2015. A copy of the SCPD's August 26, 2015 letter is attached for facilitated reference. The Department of Education is now adopting a final regulation incorporating some revisions prompted by the commentary.

The Councils recommended adoption of the following clarifying provision in three (3) sections: "Consistent with the annual budget epilog, the requirements in this subsection are suspended until fully funded by the General Assembly." The DOE agreed with the concept and adopted the following variation in the three (3) sections: "This requirement shall be effective when the General Assembly appropriates funding for this purpose."

Since the regulation is final, and the DOE adopted the above revisions, no further action is necessary.

### 2. DOE Final K-12 School Counseling Program Regulation [19 DE Reg. 305 (10/1/15)]

The SCPD and GACEC commented on the proposed version of this regulation in August, 2015. A copy of the GACEC's August 31 letter is attached for facilitated reference. The Department of Education is now adopting a final regulation with no changes.

The Councils essentially endorsed the proposed standards subject to the DOE's consideration of whether the regulation should apply to charter schools. The DOE determined that adding charter school coverage to the regulation would be somewhat redundant:

The Department of Education notes that charter schools have documented plans for addressing special needs, such as counseling, and such plans are updated every five years. The Department of Education does not believe it is necessary to change the regulation, as it would be redundant to require charter schools to create a separate school counseling plan given the detailed documentation (which addresses counseling as well as other issues) they are required to submit upon charter approval and during the application process.

At 305-306.

While redundancy should be avoided, I note that the practical effect of the exemption is that charter schools would not be required to align their counseling programs to the latest edition of the American School Counselor Association (ASCA) National Model. Moreover, submission of an annual counseling plan, as juxtaposed to incorporation of a counseling component in the general charter school update every five years, would predictably result in more on-going attention to counseling.

Since the regulation is final, and the DOE considered the Councils' commentary, no further action is necessary.

### 3. DOE Final High School Graduation & Diploma Regulation [19 DE Reg. 303 (10/1/15)]

The SCPD and GACEC commented on the proposed version of this regulation in August, 2015. A copy of the SCPD's August 26, 2015 letter is attached for facilitated reference. The Department of Education is now adopting a final regulation incorporating all edits recommended by the Councils.

First, redundant statutory references in §§10.1 and 10.2 are stricken.

Second, the authority of DSCY&F to issue credits is added to §8.1.

Third, the limiting statutory reference in §1.0 is stricken.

Since the regulation is final, and the DOE incorporated all amendments prompted by the commentary, no further action is necessary.

### 4. DOE Proposed School Psychologist Regulation [19 DE Reg. 241 (10/1/15)]

The Professional Standards Board of the Department of Education proposes to amend its standards for credentialing of school psychologists. The current standards require completion of a graduate level program of school psychology approved by either the National Association of School Psychologists (NASP) or the American Psychological Association (APA). The amendment to completion of the graduate level program is as follows: "culminating in an Masters with an additional Educational Specialist (Ed.S.) degree or its equivalent or a Doctoral degree in School Psychology".

I have the following observations.

First, the rationale for the changes is somewhat uninformative, i.e., “to clear up some language under additional requirements necessary to become a School Psychologist”. At 242.

Second, consistent with the attached information from NASP, it does appear that the current reference to “Masters with an additional Educational Specialist (Ed.S) degree” could be problematic. A graduate student may acquire essentially a single, combined degree. Moreover, the attached NASP materials indicate that it recognizes “equivalent” degrees/programs:

Specialist Degree or Equivalent (e.g. , Master’s Degree Totaling 60 Semester Credits or More)  
Please note: Many programs award a master’s degree after completing the 3<sup>rd</sup> year internship, while other programs award a master’s degree after two years of coursework prior to internship. As long as the program is a minimum of 60 credits and requires a minimum of a 1,200 hour internship, these programs are considered “specialist equivalents”.

Since the proposed amendment appears to more closely align to NASP standards, the Councils may wish to consider endorsement.

#### 5. DOE Prop. Certification Programs for Leaders in Education Reg. [19 DE Reg. 243 (10/1/15)]

The Professional Standards Board in conjunction with the Department of Education proposes to amend its certification standards for Certification Programs for Leaders in Education. The rationale for the changes is as follows:

It is necessary to amend this regulation in order to define and set out the parameters for the approval and renewal of additional programs for Delaware leaders in education.

At 243.

The changes include the following: 1) clarifying that the standards cover assistant superintendents (§1.0); and 2) modifying the roles of the State Board of Education (SBE) and Professional Standards Board (PSB) in the process to approve initial and continuing programs.

I identified only one concern.

The DOE Secretary makes the final decision to approve both an initial and renewal application to offer a covered program (§4.15 and §4.3.3.3). However, the supporting roles of the SBE and PSB are significantly changed. Consider the following:

A. The current regulation contemplates SBE involvement in the initial review process (current §§4.1.5 and 4.1.6) and the renewal review process (current §§4.3.4.3 and 4.3.4.4). The proposed regulation strikes the SBE's involvement in the initial application review process. The opposite is true for the renewal process, i.e., the SBE remains highly involved in review of renewal applications (new §§4.3, 4.3.3.1, and 4.3.3.2).

B. The current regulation contemplates PSB involvement in both the initial review process (§§4.1.2, 4.1.3, 4.1.4, and 4.2) and renewal review process (current §§4.3.2, 4.3.4, 4.3.4.1, 4.3.4.2, 4.3.4.3, and 4.3.4.4). The new regulation strikes the PSB's involvement in the renewal review process in its entirety.

It is anomalous to recognize that the SBE has expertise to warrant involvement in the review of renewal applications but not initial applications. It is also anomalous to recognize that the PSB has expertise to warrant involvement in the review of initial applications but not renewal applications. Finally, other sections of the regulation contemplate the involvement of both the SBE and PSB in the program monitoring process (§7.0). The following table illustrates the effect of the revisions:

	INITIAL APPLICATION REVIEW AGENCY	RENEWAL APPLICATION REVIEW AGENCY	MONITORING
Current Regulation	Professional Standards Bd State Board of Education	Professional Standards Bd State Board of Education	Professional Standards Bd State Board of Education
Proposed Regulation	Professional Standards Bd	State Board of Education	Professional Standards Board State Board of Education

Logically, it would be helpful to have the same agency or agencies involved in reviewing a renewal application since they would be familiar with the original application. For example, the PSB may have recommended "special considerations or conditions" (§4.1.4) which it could target in a review of a renewal application. Moreover, since the duration of the initial approval is variable and could be short (§4.1.4), the review of a renewal application may occur within a short time of review of an original application.

I recommend sharing the above observations with the DOE, SBE, and PSB.

6. DOE Proposed School Health Record Keeping Regulation [19 DE Reg. 234 (10/1/15)]

The Department of Education proposes to adopt many revisions to its standards covering school health records.

I have the following observations.

First, in §1.0, definition of “Delaware School Health Record”, the reference to “issued medications” is unclear. Does this refer only to medications administered or provided to the student by a school nurse? Alternatively, does it refer to “prescribed” and “non-prescribed” medications? It would make sense to at least include a list of prescribed medications in the record regardless of whether the nurse is “issuing” the medication. For example, a student may present with side-effects of a drug or the nurse might otherwise consider giving the student a medication (e.g. Advil; Aspirin) which may be “contraindicated” in conjunction with a prescribed drug.

Second, in §1.0, definition of “Delaware School Health Record”, the term “mandated testing and screenings” ostensibly covers those encompassed by 14 DE Admin Code 815. However, it is limiting since it would exclude testing and screenings which are not “mandatory”. For example, if a nurse conducted an “extra” vision screening in a non-mandated grade [14 DE Admin Code 815.3.1], it would be prudent to include such results in the health record. Consider the following alternative language: “results of mandated and discretionary testing and screenings” OR “results of required and discretionary testing and screenings”.

Third, the DIAA concussion regulations include an authorization for “school nurse” screening/clearance of a student to return to play. See 14 DE Admin Code 1008.3.1.6.2 and 14 DE Admin Code 1009.3.1.6.2. School nurses are authorized to perform “sidelines” duties. See 14 DE Admin Code 1008.3.3.1 and 14 DE Admin Code 1009.3.3.1. The DIAA regulations also contemplate submission of return-to-play authorizations to a school by other health providers. See, e.g., attached DIAA return-to-play form which envisions school nurse supervision of implementation of a Return to Play Plan. Other DIAA regulations require school acquisition of medical records on student athletes. See 14 DE Admin Code 1008.3.1 and 14 DE Admin Code 1009.3.1. It would be prudent to specifically include a reference to such medical documents in the definition of “Delaware School Health Record”. For example, the definition could at least include the following reference: “student athlete health records required by DIAA regulation” or “student athlete health records compiled in implementation of DIAA regulation”.

Fourth, in §1.0, definition of “Emergency/Nursing Treatment Card”, the DOE may wish to consider adding an email address for identified classes of individuals.

Fifth, in §2.1.4, the DOE may wish to refer to “parent, guardian, or Relative Caregiver” for consistency with other regulatory sections (§1.0, definitions of “Emergency/Nursing Treatment Card” and “Student Health History Update”; §2.1.2; §4.1.1).

The Councils may wish to share the above observations with the DOE.

7. DPR Prop. Sp/Lang. Path., Audiol., & Hear. Aid Disp. Telepractice Reg [19 DE Reg. 284 (10/1/15)]

The Division of Professional Regulation proposes to adopt a telepractice regulation covering speech/language pathologists, audiologists, and hearing aid dispensers. A public hearing is scheduled on November 17 and comments are due by December 2, 2015.

I have the following observations.

First, the standards attempt to include patient/client protections to prevent misuse of telepractice. For example, §§10.2.4.1 and 10.2.4.2 require all initial evaluations, reevaluations, and discharges to occur in person. Written patient/client consent after disclosure of limitations of telepractice is also required (§10.2.2).

Second, telepractice is limited to situations in which the client is “located within the borders of the State of Delaware” (§10.2.1.2). This may be “overbroad”. For example, if a long-term client were on vacation out-of-state and wanted to “Facetime” or “Skype” with his/her clinician, that would be categorically precluded. The Board could consider some limited exception (e.g., occasional telepractice treatment session of regular client if permitted by laws of jurisdiction in which client is present).

Third, in §10.1, the definition of “telepractice” is generally based on the attached ASHA criteria. However, it is somewhat “overbroad”. For example, if a client simply emailed or called his/her therapist for advice on the phone, that “consultation” would be covered by the definition of “telepractice”. The second sentence in §10.1 is likewise very broad and includes simple “advice” and “reminders” as “telepractice”. Even a brief phone call or email between two therapists about a client amounts to “telepractice”. The Division may wish to consider adopting a more limited definition.

The Councils may wish to consider sharing the above observations with the Division.

8. DMMA Prop. Medicaid Home Health Services Reimbursement Reg. [19 DE Reg. 253 (10/1/15)]

The Division of Medicaid & Medical Assistance proposes to amend its standards for reimbursing providers for home health services. Home health services include skilled nursing services; home health aide services; therapies (OT; PT; ST); durable medical equipment; and medical supplies. CMS is prompting the initiative:

During review and subsequent approval on December 31, 2014 of Delaware’s 1915(i) Home and Community State Plan Option Amendment (Pathways to Employment), the Centers for Medicare and Medicaid Services (CMS) performed a program analysis of corresponding coverage sections not originally submitted with this SPA. This analysis revealed that the reimbursement language for home health services fails to comply with 42 CFR 430.10 and 42 CFR 447.252 which implement in part Section 1902(a)(30)(A) of the Social Security Act, to require collectively that States comprehensively describe the methodologies that they use to reimburse service providers. The methodologies must be understandable, clear, unambiguous and auditable. This amendment proposes to revise the payment methodology language for home health services.

At 255.

In general, the new methodology is a universal rate for each Home Health service type. All providers would receive the same rate for each procedure code and rates would be increased annually based on an inflation factor derived from a CMS source. Id. Reimbursement standards for durable medical equipment (DME) are being revised to reflect the discontinuation of the EPIC Plus pricing software.

I have the following observations.

First, in the section on AAC systems, first paragraph, the word “devise” should be “device”.

Second, the changes will ostensibly result in significant reductions in compensation to providers. The fiscal impact table (p. 256) projects the following savings to the State and federal government:

	Federal Fiscal Year 2016	Federal Fiscal Year 2017
General (State) Funds	\$(2,951.00)	\$(2,752.00)
Federal Funds	\$(7,543.00)	\$(7,948.00)

This has both positive and negative implications. On the one hand, it saves almost \$3 million annually in the State budget. On the other hand, it reduces by almost \$8 million Federal funds coming to State providers and may depress the availability of home health services. The effect of the lowered reimbursement methodology will be magnified by a related initiative in the October Register of Regulations. DMMA is proposing to eliminate “personal care services” altogether from the Medicaid State Plan based on the rationale that such services will be subsumed under a “home health services” category. See 19 DE Reg. 258 (10/1/15). It is inferable that this will result in an expansion of home health services formerly covered as “personal care” with low reimbursement rates. In turn, low reimbursement rates may result in worker shortages and fewer Medicaid providers.

The Councils may wish to share the above positive and negative aspects of this initiative with policymakers.

9. DMMA Prop. Deletion of Personal Care Services from Medicaid Plan [19 DE Reg. 258 (10/1/15)]

The Division of Medicaid & Medical Assistance (DMMA) proposes to delete “personal care services” from the Medicaid State Plan. Instead, DMMA posits that supports currently covered as “personal care services” will be covered as “home health services”.

DMMA provides the following rationale for the change:

During review and subsequent approval on December 31, 2014 of Delaware's 1915(i) Home and Community State Plan Option Amendment (Pathways to Employment), the Centers for Medicare and Medicaid Services (CMS) performed a program analysis of corresponding coverage sections not originally submitted with this SPA. This analysis revealed an issue that requires a state plan amendment (SPA) to sunset coverage and reimbursement methodology for Personal Care Services as personal care as a service will be provided as a component of home health services.

At 260.

I have the following observations.

First, DMMA estimates that the change "imposes no increase in cost on the General Fund as home health services is already a covered benefit..." At 260. I infer that the change will result in a decrease in both State and federal costs since DMMA is contemporaneously reducing reimbursement for home health services. See 19 DE Admin Code 253, 256 (10/1/15). In turn, reduced reimbursement for home health services may result in fewer providers.

Second, the change may also result in a reduction in available providers for non-monetary reasons. Licensing of "personal assistance services agencies" is separate from licensing of "home health agencies". Compare Title 16 Dolce §122x and 16 DE Admin Code 4469 (personal assistance licensing) with 16 Dolce §122lo and 16 DE Admin Code 4406 (home health licensing). Agencies currently providing "personal assistance services" will ostensibly have to apply for new licenses as "home health agencies".

Third, it would be unfortunate if the change results in a reduction in the scope of currently-covered services. Consider the following:

A. Licensed "personal assistance" agencies can perform any acts individuals could normally perform themselves but for functional limitations consistent with Title 24 Del.C. §1921(a)(15) and Title 16 Del.C. §122x.2. CMS has historically adopted the same broad approach for "personal care assistance" as including "a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they could normally do for themselves if they did not have a disability." See attached CMS, State Medicaid Manual, §4480C. Licensed "home health" agencies lack that authority.

B. Services provided by licensed "personal assistance" agencies are not required to be supervised by a nurse. All services provided by licensed "home health" agencies must be supervised by a registered nurse. See Title 16 Dolce §122oB(V)2.C.

C. The required qualifications of persons providing "home health services" are much more extensive than the qualifications of persons providing "personal assistance". Compare 16 DE Admin Code 4406 .1.1, definition of "home health aide", with 16 DE Admin Code 4469.1.1, definition of "direct care worker".



Fourth, it is unclear what effect the change will have on attendant services provided under the DSHP+ program. DMMA notes that “personal care services” are also known by other names “such as personal attendant services, personal assistance services, or attendant care services, etc.”. At 259. The DSHP+ contracts with MCOs require coverage of “attendant care services” independent of coverage of “home health services”. See attached excerpts from 2015 DMMA-MCO contract. One could infer that DMMA’s elimination of “personal care services” from the Medicaid program represents either actual program elimination of “attendant services” or is a precursor to such elimination.

The Councils may wish to initiate a dialog with DMMA concerning this proposed regulation.

#### 10. DMMA Prop. Private Duty Nursing Services Regulation [19 DE Reg. 245 (101/15)]

The Division of Medicaid & Medical Assistance (DMMA) proposes to amend the State Medicaid Plan and relevant policy manual by revising private duty nursing (PDN) standards.

As background, SCPD and DLP representatives met with DHSS Administration in August, 2009 to review concerns with PDN standards. An agreement was reached to revise the standards. In 2010, DMMA shared draft revisions which resulted in submission of September 16, 2011 DLP-authored comments from the SCPD. In 2015, this initiative was revived. DMMA prepared a new set of proposed revisions resulting in DLP commentary and an agreement to incorporate additional changes. See attached August 26, 2015 DMMA letter. DMMA is now formally publishing revised PDN standards for comment. The proposed standards represent a major improvement in several contexts and generally merit endorsement subject to a few considerations.

I have the following observations.

First, §1.1.4 contains the following recital: “Generally, the total cost of PDN services shall not exceed the cost of care provided in an institutional setting.” The DLP’s concern with this recital and DMMA’s response are included in Section 2 of the attached August 26, 2015 letter. Literally, it suggests that individual costs may “trump” other considerations, including the ADA’s mandate to prioritize non-institutional services. CMS has historically instructed that ADA principles should be reflected and embedded in state Medicaid program standards. See attachments. See also attached NASDDDS, “The ADA, Olmstead, and Medicaid: Implications for People with Intellectual and Developmental Disabilities (2013). The “not exceed the cost” recital provides a regulatory basis for MCOs to justify institutional placement for individuals with higher PDN needs. Moreover, the notion of “cost-effectiveness” is contained in the attached regulatory definition of “medical necessity” so its deletion in the PDN standards does not result in ignoring cost considerations. The recital should be deleted.

Second, §2.1.1 refers to a “certified registered nurse practitioner (CRNP) who has a professional license from the State to provide nursing services.” The Delaware nurse licensing law refers to “advanced practice nurses” and “advanced practice registered nurses” [24 Dolce §1902(a)(b)]. There is no definition of a “certified registered nurse practitioner. DMMA may wish to review this reference.

Third, §3.1.1.2 refers to “attending practitioner”. I recommend substituting either “prescribing practitioner” or, for consistency with §5.3.2, “primary care physician”. See analysis in attached August 26, 2015 letter, Section 10. The term “attending physician” is based on institutional care environments while PDN is limited to non-institutional settings. See §1.1.4.

Fourth, §§5.1.1 and 5.2.1 merit review. They only refer to prior authorization by DMAP through a DMMA nurse. I assume it should also refer to an MCO nurse since the standards cover both DMMA-authorized PDN and MCO-authorized PDN. See §§5.1.2 , 5.2.7 and §1.0.

Fifth, I assume that references to “DMAP” (e.g. §§5.2.4, 5.2.6 ) are generic and are intended to cover both DMMA and MCO decision-making. However, the reference to “DMMA” in §5.2.2 is “underinclusive” since it would not cover an MCO. The reference could be amended to refer to “DMAP” or “DMMA or an MCO”.

Sixth, the requirement in §5.2.1 that an initial nursing assessment be “face to face” is being deleted. Perhaps this change is in recognition of the expanded authorization for telemedicine. Otherwise, I suspect a “face to face” assessment may be “best practice” and generally more valid than a “paper” review.

Seventh, §5.2.3 merits reconsideration based on concerns reflected in the attached August 26, 2015 letter, Section 5. Consider the following:

A. The section categorically presumes that everyone qualifying for PDN will need a caregiver during non-authorized PDN hours. Some individuals may be capable of self-care during such periods and not require a caregiver.

B. The section omits the concept or expectation that an MCO or provider will include a backup component in the plan of care akin to the PAS Service Specifications.

C. The section is “at odds” with §5.3.5 which contemplates home health personnel covering non-PDN hours as juxtaposed to exclusive reliance on a caregiver.

Eighth, §5.2.6 indicates that a parent’s consent to an IEP which includes PDN equates to parental consent to use of Medicaid to fund PDN . There are two problems with this approach.

A. Some students qualifying for Medicaid-funded PDN may not yet have an IEP. They may have an IFSP (Title 16 Del.C. §§214-215) or be awaiting IEP development. For example, a student incurring a sports injury or involved in an auto accident may qualify for PDN but be in the evaluation phase of IDEA special education eligibility or, having been determined eligible, be awaiting development of an IEP.

B. Parental consent to an IEP does not equate to consent to “tap” a child’s Medicaid or private insurance benefits. Indeed, IEPs do not typically include sources of payment for services. Moreover, there is no requirement that a parent “consent” to an IEP.

Explicit parental consent to “tap” Medicaid should be required. See attached federal guidance referring to a “consent form” and requirement that “parental consent” must be obtained “each time that access to public benefits or insurance is sought”. Characterizing consent to an annual IEP as consent to accessing Medicaid for PDN does not conform to this federal guidance. Even on a practical level, PDN can change more frequently than an annual IEP (§5.2.2).

Ninth, §5.2.6 contains an incorrect legal standard for eligibility to use Medicaid to fund school-based services. The standard refers to a determination that “a school is unable to meet the medical needs of school age children who are technology dependent or for whom DMAP has determined these services to be otherwise medically necessary”. [emphasis supplied] There are two problems with the underlined provision.

A. A child could qualify for PDN for reasons apart from technological dependency.

B. Medicaid is expected to routinely fund qualifying services in schools. A school is not required to demonstrate that it cannot meet a child’s needs without resorting to Medicaid funding. See attached In re A..G., DCIS No. 5000703852 (DHSS June 22, 2000); U.S. DOE Memorandum, OSEP 00-7 (January 13, 2000), at 5 [“The law clearly states that the State Medicaid agency, as well as other public insurers of children with disabilities, shall precede the financial responsibility of the local educational agency (or State agency)”]; and HHS Policy Clarification, 18 IDELR 558 (1991).

The Councils may wish to share the above observations with DMMA. The GACEC may wish to highlight the “Ninth” observation in a separate communication to the DOE.

Attachments

E:legreg/1015bils  
F:pub/bjh/legreg/2015p&l/1015bils



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August 26, 2015

Ms. Tina Shockley, Education Associate  
Department of Education  
401 Federal Street, Suite 2  
Dover, DE 19901

RE: 19 DE Reg. 112 [DOE Proposed School Transportation Regulation]

Dear Ms. Shockley:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) proposal to amend sections of the school transportation regulation. The proposed regulation was published as 19 DE Reg. 112 in the August, 2015 issue of the Register of Regulations.

As background, the current DOE school transportation regulation requires bus drivers and aides to complete annual district-provided training. The current regulation also requires bus aides to complete an annual physical exam.

The attached Section 337 of the FY16 budget bill directs the suspension of these aspects of the regulation pending an appropriation:

(b) Notwithstanding any provision to the contrary, the additional in-service training requirements for school bus drivers and aides and annual physical examinations for aides imposed pursuant to Regulation 1150 (formerly 1105) School Transportation (14 Del.C. Section 122(d)) shall not be implemented until such time as the costs of implementing those additional requirements have been fully funded by the General Assembly.

The DOE is now implementing Section 337 by amending the pertinent sections of the school transportation regulation. SCPD has the following observations.

First, the approach adopted in §7.5 is "odd". It strikes some of the annual bus driver training standards and then recites the standards are only "effective pursuant to funding by the General Assembly". Logically, the standard should be retained in its entirety followed by the disclaimer that it is not effective until funded. The reference to "pursuant to funding by the General Assembly" could also be improved. Consider the following substitute: "Consistent with the annual budget epilog, the requirements in this subsection are suspended until fully funded by the General Assembly." This is more "informative" than an oblique reference to funding.


Second, the approach adopted in §8.2 is similarly "odd". It strikes some of the annual bus aide training standards and then recites the standards are only "effective pursuant to funding by the General

Assembly". Logically, the standard should be retained in its entirety followed by the disclaimer that it is not effective until funded. The reference to "pursuant to funding by the General Assembly" could also be improved. Consider the following substitute: "Consistent with the annual budget epilog, the requirements in this subsection are suspended until fully funded by the General Assembly."

Third, in §8.1.5, the following substitute for the final sentence should be considered: "Consistent with the annual budget epilog, the requirements in this subsection are suspended until fully funded by the General Assembly."

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

Sincerely,



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

cc: The Honorable Mark Murphy, Secretary of Education  
Mr. Chris Kenton, Professional Standards Board  
Dr. Teri Quinn Gray, State Board of Education  
Ms. Mary Ann Mieczkowski, Department of Education  
Ms. Kathleen Geiszler, Esq., Department of Justice  
Ms. Terry Hickey, Esq., Department of Justice  
Ms. Iona Kirshon, Esq., Department of Justice  
Mr. Brian Hartman, Esq.  
Developmental Disabilities Council  
Governor's Advisory Council for Exceptional Citizens

19reg112 doe-school transportation 8-26-15

**GOVERNOR'S ADVISORY COUNCIL FOR EXCEPTIONAL CITIZENS**

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August 31, 2015

Tina Shockley  
Education Associate – Policy Advisor  
Department of Education  
401 Federal Street, Suite 2  
Dover, DE 19901

**RE: 19 DE Reg. 102/14 DE Admin. Code 545 [DOE Proposed K-12 School Counseling Program Regulation (August 1, 2015)]**

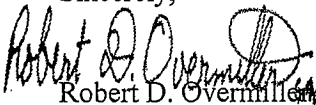
Dear Ms. Shockley:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the Department of Education proposal to revise its standards covering school counseling programs. The proposed standards are straightforward. Each school is required to implement a comprehensive school counseling program aligned with the American School Counselor Association (ASCA) model (§2.1). Each school is required to have a written plan with enumerated content (§2.2) which is submitted to the DOE annually (§3.1).

Council would like to share one observation. The standards literally apply only to district schools. See §§2.1, 2.2, and 3.1. The DOE may wish to consider whether the standards should also apply to charter schools.

Please contact me or Wendy Strauss at the GACEC office if you have any questions on our observations.

Sincerely,

  
Robert D. Overmiller  
Chairperson

RDO:kpc

CC: The Honorable Mark Murphy, Secretary of Education  
Dr. Teri Quinn Gray, State Board of Education  
Mr. Chris Kenton, Professional Standards Board  
Mary Ann Mieczkowski, Department of Education  
Matthew Korobkin, Department of Education  
Kathleen Geiszler, Esq.  
Terry Hickey, Esq.  
Ilona Kirshon, Esq.



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August 26, 2015

Ms. Tina Shockley, Education Associate  
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RE: 19 DE Reg. 100 [DOE Proposed High School Graduation & Diploma Regulation]

Dear Ms. Shockley:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) proposal to adopt amendments to its standards covering graduation requirements and diplomas. The proposed regulation was published as 19 DE Reg. 100 in the August, 2015 issue of the Register of Regulations. SCPD has the following observations.

First, the references to "pursuant to 10 Del.C. Chapter 9, §1009" in §§10.1 and 10.2 are redundant since incorporated into the definition of a "Student in DSCYF Custody." The references could be deleted as superfluous.

Second, recently enacted H.B. 116 authorizes the DSCYF to award credits to students completing courses in its education system (e.g. Ferris) or outside placements (e.g. Devereux). There is some "tension" between that authorization and §8.1 which limits awards of credits to district and charter schools. The DOE may wish to incorporate this aspect of H.B. 116 into the regulation.

Third, the multiple references to §1009 are "underinclusive". For example, §1009 only covers "post adjudication" youth. Pre-adjudication youth are covered by Title 10 Del.C. §921. A minor could also be in DSCYF custody based on other statutes, including Title 10 Del.C. §921(3)(12), Title 10 Del.C. §1007, Title 13 Del.C. Ch. 25, Title 16 Del.C. §§2210-2214, and Title 16 Del.C. §5025. The "bottom line" is that there are many statutory "routes" to DSCYF custody and/or placement. Sole reference to §1009 is clearly underinclusive. SCPD recommends deletion of the following from the definition of "Student in DSCYF Custody" – "pursuant to 10 Del.C. Chapter 9, §1009,". There's no need to include a statutory reference.

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

Sincerely,



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

cc: The Honorable Mark Murphy, Secretary of Education  
Ms. Angela Porter, DSCYF  
Mr. Steve Perales, DSCYF  
Mr. Steve Yeatman, DSCYF  
Mr. Chris McIntyre, DSCYF  
Ms. Janice Tigani, DAG  
Mr. Chris Kenton, Professional Standards Board  
Dr. Teri Quinn Gray, State Board of Education  
Ms. Mary Ann Mieczkowski, Department of Education  
Ms. Kathleen Geiszler, Esq., Department of Justice  
Ms. Terry Hickey, Esq., Department of Justice  
Ms. Ilona Kirshon, Esq., Department of Justice  
Mr. Brian Hartman, Esq.  
Developmental Disabilities Council  
Governor's Advisory Council for Exceptional Citizens  
19reg100 doe-high school graduation 8-26-15





NATIONAL  
ASSOCIATION OF  
SCHOOL  
PSYCHOLOGISTS

## A Career in School Psychology: Selecting a Master's, Specialist, or Doctoral Degree Program that Meets Your Needs

If you are reading this fact sheet, *congratulations!* Selecting the right career is an important step and deserves your careful consideration. This fact sheet provides prospective graduate students with important information on the differences between master's, specialist, and doctoral degree programs, and explores the benefits and drawbacks associated with those degrees.

### What Are Your Career Goals?

An important question prospective graduate students ask themselves is, "What are my career goals?" Answering this difficult question requires self-exploration: identifying your interests, accepting your weaknesses, and capitalizing on your strengths. In addition, it is important to identify short-term and long-term goals in relation to personal interests and aspirations, matching these goals to the various kinds of training programs. School psychology programs generally emphasize the scientist-practitioner model of practice (Fagan & Wise, 2007). The scientist-practitioner model is not aimed only at training future researchers and academicians but, particularly, at giving practitioners the tools they need to be informed consumers of research. The model promotes sufficient understanding of research methods to allow the practitioner to effectively evaluate procedures and outcomes in the school setting and to promote empirically based practices. Broadly, school psychologists tend to fall mostly in one of the following career paths:

*Practitioner in School Psychology:* Regardless of degree held, credentialed school psychologists apply the principles, research, and methods of school psychology in school settings. Services are often directly provided to clients as assessment, counseling, intervention, and prevention or indirectly as school and parent consultation, program development and evaluation, crisis prevention and intervention, wellness promotion, and school-based research. Many state credentialing agencies require the equivalent of a specialist degree in school psychology and, in a few states, attaining the NCSP and/or graduating from a NASP-approved training program.

*Administration and Policy Development:* Some school psychologists, particularly those with practitioner experience, may assume supervisory and administrative responsibilities within school districts and/or community and government agencies. Their responsibilities include direct supervision of school psychologists and other personnel, administrative tasks such as hiring, staff evaluation, budgeting, and policy development. Often such positions require an administrative or supervisory credential from the state.

*School Psychology Faculty:* These school psychologists spend the majority of their professional time training a new generation of school psychologists and conducting research in an area or areas of related interest. As trainers their emphasis is typically on transmitting the theories, research, and clinical practices of school psychology to learners, overseeing field experiences, providing exposure to research methods, and introducing them to the methods and issues of daily practice. As researchers they devote their time to studying issues related to student achievement, behavior, and mental health in order to help establish strategies that lead to improved outcomes for children and youth. Faculty members are generally required to hold a doctoral degree and should have some practical experience in school settings prior to attaining an academic appointment.

A specialist degree will typically serve as an entry level to careers as a practitioner or administrator, while a doctoral degree will usually be needed for careers in research and academia. Individuals who want to pursue—or at least leave the door open to pursuing—academic teaching and/or research are advised to seek training programs offering doctoral degrees and direct research experience, as these programs will prepare school psychologists for any of the listed career paths. Individuals committed to school-based practice who are not interested in the research requirements of most doctoral programs should seek training programs offering high standards for the attainment of specialist-level degrees with faculty and program emphases in areas of particular interest, such as early childhood, adolescent mental health, consultation, etc.

### **The Letters in Your Degree**

Have you ever wondered what the differences are between master's, specialist, and doctoral degrees? Rest assured you are not alone! It is important to become familiar with the career opportunities, advantages, and disadvantages associated with each degree, since this information can assist in guiding your program and degree decision process.

#### *Definitions of Terms*

MA	Master of Arts	PsyD	Doctor of Psychology
MS	Master of Science	EdD	Doctor of Education
MEd	Master of Education	PhD	Doctor of Philosophy
EdS	Education Specialist		
PsyS	Specialist in Psychology (only offered in a few programs)		
SSP	Specialist in School Psychology (typically offered in programs located in the southern states)		
CAGS/ CAS	Certificate of Advanced Graduate Study – typically awarded in conjunction with Masters degrees of 60 semester credits or more in programs located in the North Eastern/Eastern United States		
NCSP	Nationally Certified School Psychologist – Awarded only to school psychologists who have completed a minimum of a specialist-level program, 1,200+ hour internship, and obtained a passing score on the Praxis II exam in school psychology.		

### *Master's Degree (of Less than 60 Semester Credits)*

- Minimum graduate entrance requirements: bachelor's degree
- Completion time: Three years of graduate coursework including an internship or fieldwork for state certification.
- Advantages:
  - Practice-related coursework is often similar to specialist-level programs.
- Disadvantages:
  - Certification as a school psychologist typically requires a minimum of a specialist-level degree (i.e., master's of 60 credits or more).
  - Several states are requiring students to have graduated from NASP-approved programs or those whose content has been determined to be at a NASP-approved level.
  - The NCSP credential is only awarded to those individuals who have completed a minimum of a specialist-level program.
  - Non-doctoral level graduates are not recognized under the title of "psychologist" by the American Psychological Association (APA); however, this is generally only a problem in independent practice.
  - Employment opportunities may be significantly limited to states that accept "psychometrists" or school psychologists that graduated from programs of less than 60 semester credits.
  - Acceptance of previous graduate coursework from non APA-accredited and non NASP-approved programs towards specialist or doctoral degrees may be limited and will vary by graduate programs.



### *Specialist Degree or Equivalent (e.g., Master's Degree Totaling 60 Semester Credits or More)*

Please note: Many programs award a master's degree after completing the 3rd year internship, while other programs award a master's degree after two years of coursework prior to internship. As long as the program is a minimum of 60 credits and requires a minimum of a 1,200 hour internship, these programs are considered "specialist equivalents." To simplify hereafter, all specialist and specialist-equivalent programs will be referred to as "specialist -level" programs.

- Minimum graduate entrance requirements: bachelor's degree
- Completion time: Typically three years; however, a few programs require four years of graduate coursework including a year-long internship for certification.
- Career opportunities:
  - According to NASP, a specialist degree is considered the entry-level position for school psychology. A specialist degree in school psychology is generally accepted for certification as a school psychologist across the states, allowing for full professional practice within a public school setting. Some states also require attainment of the NCSP and/or graduation from a NASP-approved graduate program regardless of the degree awarded or hours completed.
- Advantages:
  - Specialist-level graduates are eligible for national certification in school psychology (NCSP). Note: Graduates of NASP-approved programs are assured eligibility for the NCSP, pending successful completion of the 1,200-hour internship and a passing score on the ETS School Psychology Praxis II exam.
  - Practice-related coursework is often similar or identical to coursework required in

- school psychology doctoral programs.
- Specialist programs are shorter in duration than doctoral programs, and many students have fieldwork or practicum opportunities in the schools during the first year of coursework.
- Typically training programs accept more specialist-level students than doctoral-level students on a yearly basis.
- A specialist degree may allow for non-tenure track university positions such as lecturer or adjunct faculty member.
- After three years of full-time employment, school psychologists with master's or specialist degrees are eligible to provide field-based supervision to school psychology trainees and interns.
- Schools psychologists with specialist degrees are well respected in the field and comprise the majority of currently employed school psychologists in the nation.
- Disadvantages:
  - Most programs require full-time educational plans beginning in the fall semester.
  - Admission to specialist-level programs is competitive.
  - It may be more difficult to obtain higher -level administrative positions in a school district without a doctorate and/or administrative credential.
  - Attending specialist programs that are not approved by NASP can make it difficult to obtain positions nationally if the program has lower standards that preclude state certification.
  - A few states make it difficult to obtain a school psychology credential if the specialist-level program is not NASP-approved.
  - Assistantships, grants, and fellowships to pay for graduate education tend to be more limited than those of doctoral programs.
  - Career opportunities outside the school setting may be limited depending on the state.
  - Non-doctoral level graduates are not recognized under the title of "psychologist" by the APA, thus restricting opportunities for independent practice.
  - If you decide to pursue a doctoral degree, your doctoral program may require additional internship experience and may not transfer all of your previous graduate coursework (number of credits transferred varies greatly across programs).

### **PhD, EdD, PsyD: What Are the Differences?**

In the field of school psychology, there are typically three different doctoral degrees awarded: the PhD, EdD, and PsyD, with the majority of programs awarding the PhD. Currently, there are 64 doctoral level programs approved by NASP. Of those, 45 are accredited by APA with an additional eight APA-accredited programs considered "combined" professional programs. Of the APA-accredited doctoral programs in school psychology, six offer the PsyD. Of these programs, four are also NASP-approved. *Note: APA does not accredit specialist or master's level programs.*

A few main distinctions among the three different doctoral degrees in school psychology are mentioned below. These distinctions are specific to the field of school psychology and describe what is generally known about the APA-accredited and/or NASP-approved programs currently in existence.

***In graduate school:*** The number of required credits varies across programs and is unrelated to the “type” of doctoral degree. Generally speaking, EdD training focuses on skills and theory directed towards educational practice. For the PsyD, training typically focuses on areas of clinical work, and is preferred by students with less interest in research. PhD coursework tends to be more theoretical and experimental in nature. While all types of doctoral degrees in school psychology require a dissertation, the type of dissertation will vary in focus, depth, and breadth according to the degree orientation.

***In academia:*** The PhD is notably considered the “research” degree, and the majority of individuals in academia hold this distinction. Universities and research/test publishing firms typically employ individuals with a doctoral degree (PhD, EdD, PsyD) and related experience.

***In the schools:*** In the school setting, the type of doctoral degree earned does not typically differentiate pay scale or job opportunity. Additionally, in the school setting a doctoral degree *does not guarantee* a differentiation in pay from that of a fellow non-doctoral school psychologist. *If* a doctoral stipend is offered to a practicing school psychologist, it is usually offered to anyone holding a “doctorate.” Lastly, positions such as an administrator (e.g., special education director) are typically held by individuals holding an appropriate administrative credential and any of the above doctorates.

***In clinical and private practice:*** Information from states’ psychology licensing boards supports the conclusion that minimum requirements of a “doctoral” degree for practice are not specific with regard to the type of doctoral degree needed. However, each state licensing board specifies a minimum number of hours of internship, practice, types of experience, specific coursework, and the need to have graduated from an accredited program in order to obtain licensure. In addition, some states require training in specific fields of psychology (e.g., clinical, counseling psychology) for private practice. Regardless of what type of school psychology doctoral degree, it is important to examine state requirements to ensure that the program of interest meets the minimum requirements for state board licensure.

*Some states allow for private practice with a specialist-level degree. Please see your states’ psychology board for the specific credentialing/licensing requirements.*

### ***Doctoral Degree***

Minimum entrance requirements: bachelor’s degree

- Completion time: Typically five to seven years of post-baccalaureate study, including a year of internship.
- Features:
  - A dissertation is required.
  - Programs incorporate research training into program objectives.
  - Training in a variety of theoretical orientations is available.
- Career opportunities:
  - Prepares students for careers as either academicians or practitioners.
  - Helps prepare students to sit for the state licensing exam for independent practice as licensed psychologists in a variety of settings.

- Advantages:
  - Opportunities for advanced research experiences (e.g., a dissertation).
  - Doctoral designation in practice (e.g., “Dr. Smith”) may be regarded as increasing credibility in some settings.
  - Doctoral-level graduates are recognized as Full member psychologists by the APA.
  - Most doctoral students obtain assistantships and other forms of financial assistance.
  - At a state level, graduates are eligible for licensure as an independent psychologist if they complete the appropriate coursework, document supervised hours of clinical experience, and pass the national licensing examination. Additional requirements vary by state.
  - In addition to public schools, many doctoral-level graduates may work in a range of settings including mental health centers and clinics, hospitals, universities, research firms, testing companies, or private practice.
- Disadvantages:
  - Most programs require full-time educational plans beginning in the fall semester.
  - Admittance to doctoral programs is very competitive.
  - Attending doctoral programs that are not APA-accredited or approved by NASP can make it difficult to obtain academic positions as APA-accredited or NASP-approved programs typically require faculty to have graduated from an APA-accredited or NASP-approved program.
  - Attending doctoral programs that are not APA-accredited or approved by NASP can make it difficult to obtain positions nationally if the program has lower standards that preclude state certification and licensure.
  - Psy.D. programs typically offer little or less financial assistance in comparison to Ph.D. programs.

### **A Note on Training Standards**

Both specialist and doctoral programs may receive NASP program approval. NASP-approved school psychology programs provide the education and training aligned with NASP’s training standards, giving applicant’s confidence that the curriculum and sequence of training meet the goals of the national association. This is important because NASP provides support and essential guidance to the profession. However, programs without NASP approval are not necessarily of lower quality. Some programs choose not to go through the approval process even though they would likely qualify for NASP approval. Additionally, newer programs require time to develop a track record, demonstrating that they meet NASP standards.

Many employers prefer individuals who graduate from NASP-approved programs. In addition, graduates from NASP-approved program typically have an easier time becoming Nationally Certified School Psychologists (NCSP). The NCSP is a national standard that is viewed as a measure of professionalism by potential employers and other professionals. Currently, 29 states accept the NCSP as an alternative route to state credentialing as a school psychologist.

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## Suggested Websites

[American Psychological Association: Applying to Grad School](#)  
[Becoming a School Psychologist](#)

*This fact sheet was initiated by Janeann M. Lineman, Ph.D., NCSP, and Bethany Mildren while they were graduate students in school psychology at Barry University and the University of Kansas, respectively, and prepared by Anna M. Peña, NCSP during her tenure as a graduate assistant in the NASP office.*

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National Association of School Psychologists

# Standards for the Credentialing of School Psychologists

2010

## INTRODUCTION

The mission of the National Association of School Psychologists (NASP) is to represent school psychology and support school psychologists to enhance the learning and mental health of all children and youth. NASP's mission is accomplished through identification of appropriate evidence-based education and mental health services for all children; implementation of professional practices that are empirically supported, data driven, and culturally competent; promotion of professional competence of school psychologists; recognition of the essential components of high-quality graduate education and professional development in school psychology; preparation of school psychologists to deliver a continuum of services for children, youth, families, and schools; and advocacy for the value of school psychological services, among other important initiatives.

*School psychologists* provide effective services to help children and youth succeed academically, socially, behaviorally, and emotionally. School psychologists provide direct educational and mental health services for children and youth, as well as work with parents, educators, and other professionals to create supportive learning and social environments for all children. School psychologists apply their knowledge of both psychology and education during consultation and collaboration with others. They conduct effective decision making using a foundation of assessment and data collection. School psychologists engage in specific services for students, such as direct and indirect interventions that focus on academic skills, learning, socialization, and mental health. School psychologists provide services to schools and families that enhance the competence and well-being of children, including promotion of effective and safe learning environments, prevention of academic

and behavior problems, response to crises, and improvement of family-school collaboration. The key foundations for all services by school psychologists are understanding of diversity in development and learning; research and program evaluation; and legal, ethical, and professional practice. All of these components and their relationships are depicted in Appendix A, a graphic representation of a national model for comprehensive and integrated services by school psychologists. School psychologists are credentialed by state education agencies or other similar state entities that have the statutory authority to regulate and establish credentialing requirements for professional practice within a state. School psychologists typically work in public or private schools or other educational contexts.

The NASP *Standards for Credentialing of School Psychologists* are designed to be used in conjunction with the NASP *Standards for Graduate Preparation of School Psychologists*, NASP *Model for Comprehensive and Integrated School Psychological Services*, and NASP *Principles for Professional Ethics* to provide a unified set of national principles that guide graduate education, credentialing, professional practice and services, and ethical behavior of effective school psychologists. These NASP policy documents are intended to define contemporary school psychology; promote school psychologists' services for children, families, and schools; and provide a foundation for the future of school psychology. These NASP policy documents are used to communicate NASP's positions and advocate for qualifications and practices of school psychologists with stakeholders, policy makers, and other professional groups at the national, state, and local levels.

The purpose of this document is to provide guidance to state education agencies and other state and national agencies for credentialing school psychologists and regulating the practice of school psychology. These



credentialing standards were developed and approved by NASP pursuant to its mission to support school psychologists, to enhance the learning and mental health of children and youth, and to advance the standards of the school psychology profession.

Credentialing is a process by which a state agency authorizes—and reauthorizes—the use of the title “school psychologist” (or related titles) and practice of school psychology by individuals who initially meet established standards of graduate education and then later comply with standards for continuing professional development, ethical behavior, and experience. These credentialing standards relate to both the use of the title “school psychologist” and to the practice of school psychology, which is defined by the National Association of School Psychologists’s (NASP) *Model for Comprehensive and Integrated School Psychological Services* (2010).

The *Standards for the Credentialing of School Psychologists* are intended as a model for state education agencies or other state or local entities that employ school psychologists and have the statutory authority to establish and regulate credentialing for school psychologists’ title and practice. Included are recommended criteria for initial credentialing (consisting of graduate coursework, practica, and internship requirements) as well as recommendations for credential renewal (i.e., supervision, mentoring, and professional development). These criteria are most applicable to the credentialing of persons employed as school psychologists in public or private schools. Such employment settings typically have a primary responsibility for the safety and welfare of clients served by their employees. For example, state education agencies and local school boards that employ school psychologists and other professionals have a legal responsibility for ensuring that their employees are qualified and act in accordance with various legal and regulatory mandates in their professional relationships with students and parents served by those schools. Similar responsibilities are fulfilled by the administration of other organizations with education programs in which school psychologists might work, such as hospitals or juvenile justice institutions.

NASP recognizes that states vary in the operation of their credentialing systems. Most states conduct their own initial credentialing of school psychologists but may delegate some of their regulatory responsibilities to local education agencies and/or other entities. In addition, multiple state education agency departments are typically involved in the regulation of school psychology with regard to employment, job descriptions, funding, performance evaluation, professional development, ser-

vice provision, etc. Some aspects of credentialing may be embodied in state laws; most are incorporated in regulations. However, the *Standards* are intended to provide guidance regarding credentialing and regulation of school psychology regardless of a state’s organizational and legal structure.

The *Standards* also include a description of the *Nationally Certified School Psychologist* (NCSP) credential, a model implementation of these standards as administered by the National School Psychology Certification Board. The NCSP is a national certification system for school psychologists based upon recognized standards for advanced preparation, performance-based assessment of competency and demonstration of positive outcomes for consumers of school psychological services. The National School Psychology Certification System (NSPCS) was created by NASP to establish a nationally recognized standard for credentialing school psychologists. The *Standards for the Credentialing of School Psychologists* are used by the NSPCS, and the NCSP is bestowed upon individuals in recognition of meeting national standards. The *Standards for the Credentialing of School Psychologists* are also considered to be appropriate for states to use in executing their authority in credentialing school psychologists. As a result, the NCSP credential is widely recognized by state education agencies as a valid approach for credentialing school psychologists. These *Standards* are not intended to supplant a state’s authority to implement equivalent credentialing processes for school psychologists. The purposes of this national credentialing system are to promote uniform credentialing standards across states, agencies, and training institutions, and to facilitate the credentialing of school psychologists across states through the use of equivalency. The National Association of School Psychologists’s designation for persons who meet these standards is *Nationally Certified School Psychologist*, or NCSP. Persons who hold the NCSP are considered to have met rigorous standards of training and competency based upon the assessment and demonstration of effective services and positive impact on students, families, and learning environments.

## THE STRUCTURE OF THE SCHOOL PSYCHOLOGIST CREDENTIAL

### 1.0 State Credentialing Authority

- 1.1 Credentialing for school psychologists (i.e., licensure or certification) is the process whereby a state authorizes individuals to use the title “school

psychologist” and provide school psychological services. Credentialing in school psychology is granted to individuals meeting established standards of graduate education and experience. A state’s credentialing authority, found in statute and/or regulations, should require all providers of school psychological services and all users of the title “school psychologist” to hold a current credential, and provide for legal sanctions and sanctioning procedures for violators.

- 1.2 When a state empowers one or more organizational entities to administer the credentialing (certification and/or licensure) process for school psychologists, administrative codes and regulations adopted by such bodies should be consistent with the *Standards for the Credentialing of School Psychologists* and carry the weight of law.

## 2.0 Elements of the School Psychologist Credential

- 2.1 The credential should be issued in writing and expressly authorize both the practice of school psychology as defined by *NASP Model for Comprehensive and Integrated School Psychological Services* and the use of the title “school psychologist.”
- 2.2 The professional school psychologist credential should be issued for a minimum period of three years.
- 2.3 The minimum requirement for a professional credential as a school psychologist is the specialist-level credential in school psychology per the criteria in section 3.0.
- 2.4 The credentialing process should require at least one academic year of postdegree supervision and/

or mentoring following initial issuance of the credential. (See Section 5.5).

- 2.5 Following the completion of one year of supervision, the credential should allow school psychologists to have professional autonomy in determining the nature, scope, and extent of their specific services consistent with their training, supervised experience, and demonstrated expertise and in accordance with *NASP’s Principles for Professional Ethics* (2010).
- 2.6 It is recommended that state and local education agencies incorporate *NASP’s Model for Comprehensive and Integrated School Psychological Services* (2010) in any performance evaluation system used to evaluate school psychologists.

## STATE CREDENTIALING REQUIREMENTS

### 3.0 Criteria for Specialist-Level Credentialing in School Psychology

- 3.1 The minimum requirement for credentialing as a school psychologist shall be a specialist-level program of study in school psychology consisting of the following: (a) a minimum of three years of full-time study at the graduate level, or the equivalent if part-time; (b) at least 60 graduate semester hours or the equivalent<sup>1</sup>, with at least 54 hours exclusive of credit for the supervised specialist level internship experience; and (c) institutional documentation of specialist-level school psychology program completion<sup>2,3</sup> provided to graduates.

Criteria for each of the following areas will be consistent with *NASP Standards for Graduate Preparation of School Psychologists*<sup>4</sup>.

<sup>1</sup> Graduate semester hours are units of graduate credit based on a semester course schedule. In cases in which a quarter schedule is used, three quarter hours equals two semester hours. Thus, 90 quarter hours of credit are essentially equivalent to 60 semester hours. Programs that utilize other credit systems (e.g. trimester credits, unit credits) provide candidates with institution policy regarding their equivalency to a semester hour system.

<sup>2</sup> Institutional documentation of program completion is “official” documentation provided by the higher education institution (or by a unit of the institution) that an individual has completed the entire required program of study in the school psychology program, including the internship. Institutional documentation is typically in the form of a degree or diploma, certificate of advanced graduate studies, transcript notation indicating program completion, or similar documentation of completion of the entire school psychology program.

<sup>3</sup> Various types of institutional documentation may be used to recognize “specialist-level” program completion in school psychology, defined as a program consisting of a minimum of 60 graduate semester hours or the equivalent and including the internship. The following are *examples* of institutional documentation of specialist level program completion: master’s degree requiring 60+ semester hours, master’s degree plus certificate of advanced study (e.g., CAS, CAGS) totaling 60+ semester hours, Educational Specialist (EdS) or Psychology Specialist (PsyS) degree requiring 60+ semester hours, etc.

<sup>4</sup> The *NASP Standards for Graduate Preparation of School Psychologists* are approved by the National Council for Accreditation of Teacher Education (NCATE) and are utilized by NASP when it conducts graduate program reviews as a part of the NCATE unit accreditation process.

3.2 Domains of Professional Practice. The credential should be based upon the completion of an integrated and sequential program of study that is explicitly designed to develop knowledge and practice competencies in each of the following Domains of Professional Practice. School psychologists provide comprehensive and integrated services across 10 general domains of school psychology, as illustrated in Appendix A. The 10 domains of school psychology reflect the following principles:

- ◆ School psychologists have a foundation in the knowledge bases for both psychology and education, including theories, models, research, empirical findings, and techniques in the domains, and the ability to explain important principles and concepts.
- ◆ School psychologists use effective strategies and skills in the domains to help students succeed academically, socially, behaviorally, and emotionally.
- ◆ School psychologists apply their knowledge and skills by creating and maintaining safe, supportive, fair, and effective learning environments and enhancing family-school collaboration for *all* students.
- ◆ School psychologists demonstrate knowledge and skills relevant for professional practices and work characteristics in their field.
- ◆ School psychologists ensure that their knowledge, skills, and professional practices reflect understanding and respect for human diversity and promote effective services, advocacy, and social justice for all children, families, and schools.
- ◆ School psychologists integrate knowledge and professional skills across the 10 domains of school psychology in delivering a comprehensive range of services in professional practice that result in direct, measurable outcomes for children, families, schools, and/or other consumers.

Professional preparation should reflect the ability to integrate knowledge and skills across each of the following domains. Competency requires demonstration of both knowledge and skills. The descriptions below are representative of competencies in each domain but are not intended to be exhaustive or prescriptive. Appendix A represents the 10 domains within a model of

comprehensive and integrated services by school psychologists. In addition, the NASP (2010) *Model for Comprehensive and Integrated School Psychological Services* presents specific school psychology practices and provides more detail about the integrated and comprehensive nature of the 10 domains below.

### **1. Data-Based Decision Making and Accountability**

- School psychologists have knowledge of varied methods of assessment and data-collection methods for identifying strengths and needs, developing effective services and programs, and measuring progress and outcomes.
- As part of a systematic and comprehensive process of effective decision making and problem solving that permeates all aspects of service delivery, school psychologists demonstrate skills to use psychological and educational assessment and data collection strategies, and technology resources, and apply results to design, implement, and evaluate response to services and programs.

### **2. Consultation and Collaboration**

- School psychologists have knowledge of varied methods of consultation, collaboration, and communication applicable to individuals, families, groups, and systems and used to promote effective implementation of services.
- As part of a systematic and comprehensive process of effective decision making and problem solving that permeates all aspects of service delivery, school psychologists demonstrate skills to consult, collaborate, and communicate with others during design, implementation, and evaluation of services and programs.

### **3. Interventions and Instructional Support to Develop Academic Skills**

- School psychologists have knowledge of biological, cultural, and social influences on academic skills; human learning, cognitive, and developmental processes; and evidence-based curriculum and instructional strategies.
- School psychologists, in collaboration with others, demonstrate skills to use assessment and data-collection methods and to implement and evaluate services that support cognitive and academic skills.

#### **4. Interventions and Mental Health Services to Develop Social and Life Skills**

- School psychologists have knowledge of biological, cultural, developmental, and social influences on behavior and mental health; behavioral and emotional impacts on learning and life skills; and evidenced-based supported strategies to promote social-emotional functioning and mental health.
- School psychologists, in collaboration with others, demonstrate skills to use assessment and data collection methods and implement and evaluate services to support socialization, learning, and mental health.

#### **5. School-Wide Practices to Promote Learning**

- School psychologists have knowledge of school and systems structure, organization, and theory; general and special education; and empirically supported school practices that promote academic outcomes, learning, social development, and mental health.
- School psychologists, in collaboration with others, demonstrate skills to develop and implement practices and strategies to create and maintain effective and supportive learning environments for children and others.

#### **6. Preventive and Responsive Services**

- School psychologists have knowledge of principles and research related to resilience and risk factors in learning and mental health, services in schools and communities to support multitiered prevention, and empirically supported strategies for effective crisis response.
- School psychologists, in collaboration with others, demonstrate skills to promote services that enhance learning, mental health, safety, and physical well-being through protective and adaptive factors and to implement effective crisis preparation, response, and recovery.

#### **7. Family-School Collaboration Services**

- School psychologists have knowledge of principles and research related to family systems, strengths, needs, and culture; empirically supported strategies to support family influences on children's learning, socialization, and mental health; and methods to develop collaboration between families and schools.

- School psychologists, in collaboration with others, demonstrate skills to design, implement, and evaluate services that facilitate family and school partnerships and interactions with community agencies for enhancement of academic and social-behavioral outcomes for children.

#### **8. Development and Learning**

- School psychologists have knowledge of individual differences, abilities, disabilities, and other diverse characteristics; principles and research related to diversity factors for children, families, and schools, including factors related to culture, context, individual, and role differences; and empirically supported strategies to enhance services and address potential influences related to diversity.
- School psychologists demonstrate skills to provide professional services that promote effective functioning for individuals, families, and schools with diverse characteristics, cultures, and backgrounds, and across multiple contexts with recognition that an understanding and respect for diversity in development and advocacy for social justice are foundations for all aspects of service delivery.

#### **9. Research and Program Evaluation**

- School psychologists have knowledge of research design, statistics, measurement, varied data-collection and analysis techniques, and program evaluation methods sufficient for understanding research and interpreting data in applied settings.
- School psychologists demonstrate skills to evaluate and apply research as a foundation for service delivery and, in collaboration with others, use various techniques and technology resources for data collection, measurement, analysis, and program evaluation to support effective practices at the individual, group, and/or systems levels.

#### **10. Legal, Ethical, and Professional Practice**

- School psychologists have knowledge of the history and foundations of school psychology; multiple service models and methods; ethical, legal, and professional standards; and other factors related to professional identity and effective practice as school psychologists.
- School psychologists demonstrate skills to provide services consistent with ethical, legal, and professional standards; engage in responsive ethical and profes-

sional decision-making; collaborate with other professionals; and apply professional work characteristics needed for effective practice as school psychologists, including respect for human diversity and social justice, communication skills, effective interpersonal skills, responsibility, adaptability, initiative, dependability, and technology skills.

3.3 Applicants for a school psychology specialist credential will have completed supervised practica experiences<sup>5</sup> that include the following:

- a. Completion of practica, for academic credit or otherwise documented by the institution, that are distinct from, precede, and prepare candidates for the school psychology internship.
- b. Specific, required activities and systematic development and evaluation of skills, consistent with goals of the program, emphasize human diversity, and are completed in settings relevant to program objectives for development of candidate skills (See Standards 3.2 Domains of Professional Practice)
- c. Direct oversight by the program to ensure appropriateness of the placement, activities, supervision, and collaboration with the placement sites and practicum supervisors
- d. Close supervision by program faculty and qualified practicum supervisors, including appropriate performance-based evaluation by program faculty and supervisors to ensure that candidates are developing professional work characteristics and designated competencies

3.4 Applicants for a school psychology credential will have completed a comprehensive, supervised, and

carefully evaluated internship<sup>6</sup> consisting of the following<sup>7</sup>:

- a. A minimum of 1200 clock hours for specialist-level interns, including a minimum of 600 hours of the internship completed in a *school setting*<sup>8</sup>
- b. A minimum of one academic year, completed on a full-time basis or on a half-time basis over two consecutive years
- c. Completion in settings relevant to program objectives for candidate competencies and direct oversight by the program to ensure appropriateness of the placement, activities, and field supervision
- d. A culminating experience in the program's course of study that is completed for academic credit or otherwise documented by the institution
- e. A primary emphasis on providing breadth and quality of experiences, attainment of comprehensive school psychology competencies, and integration and application of the full range of domains of school psychology graduate education and practice (See Standards 2.1 to 2.10)
- f. Completion of activities and attainment of school psychology competencies consistent with the goals and objectives of the program, and which emphasize human diversity, and delivery of professional school psychology services that result in direct, measurable, and positive impact on children, families, schools, and/or other consumers
- g. Inclusion of both formative and summative performance-based evaluations of interns that are completed by both program faculty and

<sup>5</sup> School psychology practica are closely supervised on-campus and/or field-based activities designed to develop and evaluate school psychology candidates' mastery of specific professional skills consistent with program goals. Practica activities may be completed as part of separate courses focusing on distinct skills or as part of a more extensive field experience that covers a range of skills. Candidate skill and competency *development*, rather than delivery of professional services, is a primary purpose of practica.

<sup>6</sup> The school psychology internship is a supervised, culminating, comprehensive field experience that is completed prior to the awarding of the degree or other institutional documentation of completion of the specialist- or doctoral-level program. The internship ensures that school psychology candidates have the opportunity to integrate and apply professional knowledge and skills acquired in program coursework and practica, as well as to acquire enhanced competencies consistent with the school psychology program's goals and objectives.

<sup>7</sup> See *Best Practice Guidelines for School Psychology Internships* for an additional resource for graduate programs and internship sites, available on the NASP website.

<sup>8</sup> A "school setting" is one in which the primary goal is the education of students of diverse backgrounds, characteristics, abilities, disabilities, and needs. Generally, a school setting includes students who are enrolled in Grades pre-K-12 and has both general education and special education services. The school setting has available an internal or external pupil services unit that includes at least one state-credentialed school psychologist and provides a full range of school psychology services. Other internship settings, if allowed by the program beyond the 600 hours in a school setting, are consistent with program objectives and may include relevant school psychology activities in other educational contexts within, for example, hospitals, juvenile justice institutions, and community agencies that provide collaborative services for schools.

field-based supervisors, are systematic and comprehensive, and ensure that interns demonstrate professional work characteristics and attain competencies needed for effective practice as school psychologists

- h. Provision of field supervision from a school psychologist holding the appropriate state school psychology credential for practice in the internship setting (or, if a portion of the internship is conducted in a another setting, as noted in Standard 3.4a, provision of field supervision from a psychologist holding the appropriate state psychology credential for practice in the internship setting)
  - i. An average of at least two hours of field-based supervision per full-time week or the equivalent for half-time placements
  - j. Preponderance of field-based supervision provided on at least a weekly, individual, face-to-face basis, with structured mentoring and evaluation that focus on development of the intern's competencies
- 3.5 Documentation is provided that the applicant has demonstrated the ability to integrate domains of knowledge and apply professional skills in delivering a comprehensive range of services evidenced by measurable positive impact on children, youth, families, and other consumers.
- 3.6 Applicants should achieve a passing score on a state or national test appropriate for school psychology. The National School Psychology Certification Board has established a passing score on the Educational Testing Service's (ETS) School Psychology Examination that is suitable for state credentialing purposes.

#### 4.0 Criteria for Doctoral Credential in School Psychology

- 4.1 A doctoral-level credential in school psychology should be based upon (a) a minimum of 4 years of full-time study at the graduate level or the equivalent, if part time (b) at least 90 graduate semester hours or the equivalent, with at least

78 hours exclusive of credit for the supervised doctoral internship experience and any terminal doctoral project (e.g., dissertation), and (c) institutional documentation of school psychology doctoral-level program completion provided to graduates. Criteria for each of the following areas will be consistent with NASP *Standards for Graduate Preparation of School Psychologists*.

- 4.2 The credential should be based upon the completion of an integrated and sequential program of study in school psychology<sup>9</sup> that is explicitly designed to develop knowledge and practice competencies in each of the following Domains of Professional Practice.
- a. Data-Based Decision Making and Accountability
  - b. Consultation and Collaboration
  - c. Interventions and Instructional Support to Develop Academic Skills
  - d. Interventions and Mental Health Services to Develop Social and Life Skills
  - e. School-Wide Practices to Promote Learning
  - f. Preventive and Responsive Services
  - g. Family-School Collaboration Services
  - h. Diversity in Development and Learning
  - i. Research and Program Evaluation
  - j. Legal, Ethical, and Professional Practice
- 4.3 Applicants for a school psychology doctoral credential will have completed supervised practica experiences that include the following:
- a. Completion of practica, for academic credit or otherwise documented by the institution, that are distinct from, precede, and prepare candidates for the school psychology internship.
  - b. Specific, required activities and systematic development and evaluation of skills, consistent with goals of the program and in settings relevant to program objectives for development of candidate skills (See Standards 2.1 to 2.10)
  - c. Direct oversight by the program to ensure appropriateness of the placement, activities,

<sup>9</sup> Greater depth in one or more school psychology competencies identified by the program in its philosophy/mission of doctoral-level preparation and reflected in program goals, objectives, and sequential program of study and supervised practice. (Doctoral programs typically are characterized by advanced competencies in research, and the program may identify additional competencies that address the specific philosophy/mission, goals, and objectives of its doctoral program of study, e.g., greater depth in one or more domains described in Standards 2.1 to 2.10, a practice specialization, supervision or leadership competency, preparation for specialized roles or settings such as research or graduate instruction).

- supervision, and collaboration with the placement sites and practicum supervisors
- d. Close supervision by program faculty and qualified practicum supervisors and inclusion of appropriate performance-based evaluation by program faculty and supervisors to ensure that candidates are developing professional work characteristics and designated competencies
- 4.4 Applicants for a school psychology doctoral credential will have completed a comprehensive, supervised, and carefully evaluated internship consisting of the following:
- a. A minimum of 1500 clock hours for doctoral-level interns<sup>10</sup>, including a minimum of 600 hours of the internship completed in a *school setting*.
  - b. A minimum of one academic year for internship, completed on a full-time basis over one year or at least a half-time basis over two consecutive years
  - c. Completion in settings relevant to program objectives for candidate competencies and direct oversight by the program to ensure appropriateness of the placement, activities, and field supervision
  - d. A culminating experience in the program's course of study that is completed for academic credit or otherwise documented by the institution
  - e. A primary emphasis on providing breadth and quality of experiences, attainment of comprehensive school psychology competencies, and integration and application of the full range of domains of school psychology graduate education and practice (See Standards 2.1 to 2.10)
  - f. Completion of activities and attainment of school psychology competencies consistent with the goals and objectives of the program and delivery of professional school psychology services that result in direct, measurable, and positive impact on children, families, schools, and/or other consumers
- g. Both formative and summative performance-based evaluations of interns that are completed by both program faculty and field-based supervisors, are systematic and comprehensive, and ensure that interns demonstrate professional work characteristics and attain designated competencies needed for effective school psychology practice
  - h. Provision of field supervision from a school psychologist holding the appropriate state school psychology credential for practice in the internship setting (or, if a portion of the internship is conducted in a another setting, as noted in Standard 4.4a, provision of field supervision from a psychologist holding the appropriate state psychology credential for practice in the internship setting)
    - i. An average of at least 2 hours of field-based supervision per full-time week or the equivalent for part-time placements.
    - j. Preponderance of field-based supervision provided on at least a weekly, individual, face-to-face basis, with structured mentoring and evaluation that focus on development of the intern's competencies
- 4.5 Documentation is provided that the candidate has demonstrated the ability to integrate domains of knowledge and apply professional skills in delivering a comprehensive range of services evidenced by measurable positive impact on children, youth, families, and other consumers.
- 4.6 Applicants should achieve a passing score on a state or national test appropriate for school psychology. The National School Psychology Certification Board has established a passing score on the Educational Testing Service's (ETS) School Psychology Examination that is suitable for state credentialing purposes.

<sup>10</sup> Programs may allow up to half of the required 1500 *doctoral* internship hours to be used from a prior, appropriately supervised specialist-level internship or equivalent experience in school psychology if (a) the program determines that the specialist-level internship or equivalent experience meets program objectives and NASP standards for the school psychology internship (see Standards 3.2 to 3.6), (b) candidates have met program objectives and criteria for school psychology specialist-level internship competencies, and (c) any field experiences considered equivalent to a formal specialist-level internship in school psychology are clearly articulated and systematically evaluated by the program.

## STATE CREDENTIALING PROCEDURES

### 5.0 Implementation of School Psychology Credentialing Requirements by States

- 5.1 The state credential is granted to individuals who meet the requirements described in Standard 3.0, including completion of a specialist-level school psychology program consistent with NASP *Standards for Graduate Preparation of School Psychologists*, demonstration of professional work characteristics, completion of applied professional practice, and demonstrated competency in the domains of professional practice.
- 5.2 Implementation of these requirements may be facilitated in four ways:
- Applicants who are graduates of school psychology programs approved by the National Association of School Psychologists at the specialist or doctoral level will have met preparation requirements 3.0 or 4.0 respectively and are eligible for credentialing as school psychologists.
  - Applicants who are graduates of school psychology programs that, at the time of the applicant's graduation, were accredited by an agency (e.g., American Psychological Association), approved by the U.S. Department of Education, and who have met the internship requirement specified in Standard 4.4, are eligible for credentialing as school psychologists.
  - Applicants who are graduates of other graduate education programs should demonstrate equivalency with the NASP *Standards for Graduate Preparation of School Psychologists*. For applicants who hold graduate degrees in related fields and are seeking graduate preparation and credentialing as a school psychologist, the state should ensure that its requirements for alternative credentialing are consistent with these NASP credentialing standards. NASP approved graduate education programs may be consulted to ensure that an applicant's prior courses, field experiences, and professional competencies are equivalent to NASP *Standards for Graduate Preparation of School Psychologists*<sup>11</sup>.
  - Applicants who hold a valid credential as Nationally Certified School Psychologists (NCSP) have been judged by the National Association of School Psychologists to have met its graduate preparation and credentialing standards and should be considered eligible for state credentialing as school psychologists.
- 5.3 The NCSP credential is suitable for adoption by state education agencies for credentialing of school psychologists. However, comparable credentialing approaches should be available to applicants as described in Standard 5.2. Recognition of the NCSP facilitates interstate reciprocity agreements. The NCSP system can also satisfy state credential renewal requirements for continuing professional development.
- 5.4 Adequate professional support should be provided to all credentialed school psychologists. School systems should ensure that all personnel have levels and types of supervision and/or mentoring adequate to ensure the provision of effective and accountable services. Supervision and mentoring are provided through an ongoing, positive, systematic, collaborative process between the school psychologist and a school psychology supervisor or other school psychology colleagues.
- 5.5 Credentialed school psychologists in their first postgraduate year of employment should participate in district-provided supervision or mentoring. Such induction experiences should be for the purpose of establishing a foundation for lifelong learning and professional growth. For initially credentialed school psychologists, participation in district-provided supervision and/or mentoring conducted either directly or indirectly is recommended for a minimum average of 1 hour per week.
- 5.6 Supervisors have a valid school psychologist credential for the setting in which they are

<sup>11</sup> If the school psychology program provides opportunities for respecialization, retraining, or other alternative approaches to prepare candidates for credentialing as school psychologists (e.g., for candidates who hold graduate degrees in related fields and are seeking graduate preparation and credentialing as school psychologists), the program ensures that its requirements for respecialization, retraining, or alternative credentialing approaches are consistent with these NASP graduate preparation standards. The program applies systematic evaluation procedures and criteria to grant recognition of candidates' prior courses/field experiences and to identify additional graduate courses and experiences necessary for candidates to meet school psychology program requirements.



employed, and have a minimum of 3 years of experience as a practicing school psychologist. Education and/or experience in the supervision of school personnel are desirable.

- 5.7 Supervision methods should match the developmental level of the school psychologist. Novice school psychologists require more intensive supervisory modalities, including regularly scheduled sessions. Alternative methods, such as supervision groups, mentoring, and/or peer support can be utilized with more experienced school psychologists to ensure continued professional growth and support for complex or difficult cases. School systems should allow time for school psychologists to participate in supervision and mentoring.
- 5.8 The school system should develop and implement a coordinated plan for the accountability and evaluation of all school psychological services. This plan should address evaluation of both implementation and outcomes of services.
- 5.9 Renewal of the initial state credential should be granted to applicants meeting the following criteria:
  - a. Evidence of public, private, or university-based practice for a minimum of 1 academic year of full-time equivalent (FTE) experience during the previous 3 years.
  - b. Evidence of continuing professional development for a minimum of 75 clock hours during the previous 3-year period while the credential was in effect.
  - c. Evidence of having successfully completed a minimum of 1 academic year of professional experience with a mentor or supervisor. For professional practice within a school setting, supervision or mentoring should be provided

by a credentialed school psychologist with a minimum of 3 years of experience.

## 6.0 Nationally Certified School Psychologist

- 6.1 The Nationally Certified School Psychologist (NCSP) credential is granted to persons who have successfully met standards 3.0–3.7 above<sup>12</sup>.
- 6.2 For initial renewal of the NCSP credential, there should be evidence of having successfully completed a minimum of 1 academic year of professional support from a mentor or supervisor. For professional practice within a school setting, supervision or mentoring shall be provided by a credentialed school psychologist with a minimum of three years of experience. For any portion of the experience that is accumulated in a nonschool setting, supervision or mentoring shall be provided by a psychologist appropriately credentialed for practice in that setting. Supervision and/or mentoring conducted either individually or within a group for a minimum average of 1 hour per week is recommended.
- 6.3 Renewal of the NCSP will only be granted to applicants who complete at least 75 contact hours of continuing professional development activities within a 3-year period.

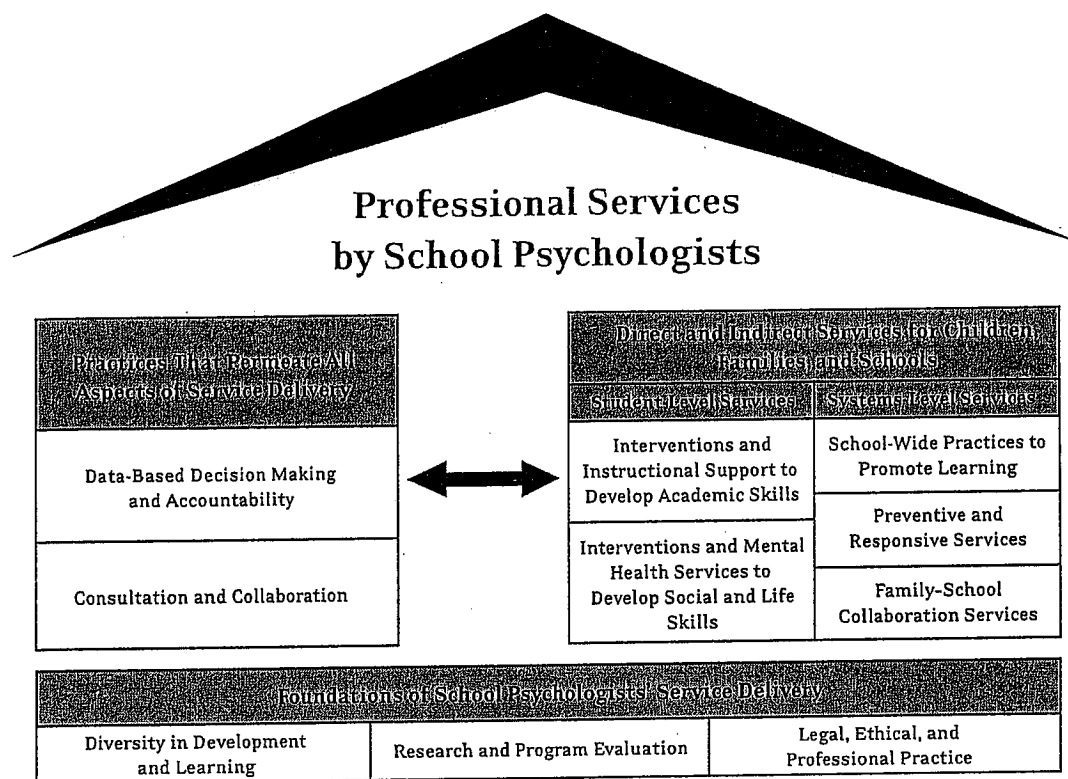
## 7.0 Principles for Professional Ethics

State and local education agencies are encouraged to adopt the NASP *Principles for Professional Ethics* and develop appropriate problem-solving, due process, and discipline procedures for addressing potential ethical misconduct by school psychologists in addition to the already established procedures for handling employee misconduct.

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<sup>12</sup> *Approved Programs in School Psychology*: The National Association of School Psychologists (NASP) publishes annually a list of graduate education programs in school psychology that have been determined to meet the NASP *Standards for Graduate Preparation of School Psychologists*. A copy of the approved program list can be obtained by contacting the National Association of School Psychologists, 4340 East West Highway, Suite 402, Bethesda, MD 20814 or at <http://www.nasponline.org>

APPENDIX A. MODEL OF COMPREHENSIVE AND INTEGRATED SERVICES BY SCHOOL PSYCHOLOGISTS



APPENDIX B. EXPANDED DESCRIPTION OF DOMAINS OF SCHOOL PSYCHOLOGY GRADUATE EDUCATION AND PRACTICE WITHIN A MODEL OF COMPREHENSIVE AND INTEGRATED SERVICES BY SCHOOL PSYCHOLOGISTS

Within the model of comprehensive and integrated services, illustrated in Appendix A, school psychologists' activities include knowledge and skills across 10 domains of school psychology. As noted in NASP Graduate Preparation Standards 2.1 to 2.10, the school psychology program ensures that all candidates demonstrate basic competencies in the 10 domains of school psychology. The domains are highly interrelated and not mutually exclusive, and should be reflected across the school psychology program of study. The NASP (2010) *Model for Comprehensive and Integrated School Psychological Services* presents specific school psychology practices and provide more detail about the integrated and comprehensive nature of the 10 domains.

Below, an expanded list of *sample areas of knowledge and skills in the domains* is provided that programs may find useful

in defining expected candidate competencies. The examples in the descriptions below are not intended to reflect the possible full range of competencies for school psychologists, but instead identify examples of knowledge and skills that school psychology graduate programs may consider when identifying their own goals and objectives for their candidates. The examples of knowledge and skill below are intended to serve only as *general guides* for the school psychology program. The program may elect to emphasize specific knowledge and skill areas from the descriptions below or may elect to identify additional knowledge and skills areas, depending on program goals and objectives, areas of specialization, specialist- or doctoral-level preparation, roles and functions for which candidates are being prepared, etc.

The following elements are apparent in the school psychology program:

**2.1 Data-Based Decision Making and Accountability**

School psychologists have knowledge of the following:

- Assessment and data collection methods relevant to a comprehensive, systematic process of effective decision making and problem solving for particular situations, contexts, and diverse characteristics
- Varied methods of assessment and data collection in psychology and education (e.g., norm-referenced, curriculum-based, direct behavior analysis, ecological) and their psychometric properties.
- Assessment and data collection methods useful in identifying strengths and needs and documenting problems of children, families, and schools
- Strategies for translating assessment and data collection to development of effective instruction, interventions, and educational and mental health services
- Assessment and data-collection methods to measure response to, progress in, and effective outcomes of services

School psychologists demonstrate *skills* to:

- Use psychological and educational assessment and data collection strategies as part of a comprehensive process of effective decision making and problem solving that permeates all aspects of service delivery
- Systematically collect data and other information about individuals, groups, and environments as key components of professional school psychology practice
- Translate assessment and data collection results into design, implementation, and accountability for empirically supported instruction, interventions, and educational and mental health services effective for particular situations, contexts, and diverse characteristics
- Use assessment and data collection methods to evaluate response to, progress in, and outcomes for services in order to promote improvement and effectiveness
- Access information and technology resources to enhance data collection and decision making
- Measure and document effectiveness of their own services for children, families, and schools

## 2.2 Consultation and Collaboration

School psychologists have *knowledge* of the following:

- Varied methods of consultation in psychology and education (e.g., behavioral, problem solving, mental health, organizational, instructional) applicable to individuals, families, groups, and systems
  - Strategies to promote collaborative, effective decision making and implementation of services among professionals, families, and others
  - Consultation and collaboration strategies effective across situations, contexts, and diverse characteristics
  - Methods for effective consultation and collaboration that link home, school, and community settings
- School psychologists demonstrate *skills* to:
- Apply consultation methods, collaborate, and communicate effectively with others as part of a comprehensive process that permeates all aspects of service delivery
  - Consult and collaborate in planning, problem solving, and decision-making processes and to design, implement, and evaluate instruction, interventions, and educational and mental health services across particular situations, contexts, and diverse characteristics
  - Consult and collaborate at the individual, family, group, and systems levels
  - Facilitate communication and collaboration among diverse school personnel, families, community professionals, and others
  - Effectively communicate information for diverse audiences, for example, parents, teachers, other school personnel, policy makers, community leaders, and/or others
  - Promote application of psychological and educational principles to enhance collaboration and achieve effectiveness in provision of services

## 2.3 Interventions and Instructional Support to Develop Academic Skills

School psychologists have *knowledge* of the following:

- Biological, cultural, and social influences on cognitive and academic skills
- Human learning, cognitive, and developmental processes, including processes of typical development, as well as those related to learning and cognitive difficulties, across diverse situations, contexts, and characteristics
- Empirically supported methods in psychology and education to promote cognitive and academic skills, including those related to needs of children with diverse backgrounds and characteristics
- Curriculum and instructional strategies that facilitate children's academic achievement, including, for example, teacher-directed instruction, literacy instruction, peer tutoring, interventions for self-regulation and planning/organization; etc.
- Techniques to assess learning and instruction and methods for using data in decision making, planning, and progress monitoring
- Information and assistive technology resources to enhance children's cognitive and academic skills

School psychologists, in collaboration with others, demonstrate *skills* to:

- Use assessment and data-collection methods to develop appropriate academic goals for children with diverse abilities, disabilities, backgrounds, strengths, and needs
- Implement services to achieve academic outcomes, including classroom instructional support, literacy strategies, home-school collaboration, instructional consultation, and other evidenced-based practices
- Use empirically supported strategies to develop and implement services at the individual, group, and systems levels and to enhance classroom, school, home, and community factors related to children's cognitive and academic skills
- Implement methods to promote intervention acceptability and fidelity and appropriate data-based decision making procedures, monitor responses of children to instruction and intervention, and evaluate the effectiveness of services

#### 2.4 Interventions and Mental Health Services to Develop Social and Life Skills

School psychologists have *knowledge* of the following:

- Biological, cultural, social, and situational influences on behavior and mental health and behavioral and emotional impacts on learning, achievement, and life skills
- Human developmental processes related to social-emotional skills and mental health, including processes of typical development, as well as those related to psychopathology and behavioral issues, across diverse situations, contexts, and characteristics
- Empirically supported strategies to promote social-emotional functioning and mental health
- Strategies in social-emotional, behavioral, and mental health services that promote children's learning, academic, and life skills, including, for example, counseling, behavioral intervention, social skills interventions, instruction for self-monitoring, etc.
- Techniques to assess socialization, mental health, and life skills and methods for using data in decision making, planning, and progress monitoring

School psychologists, in collaboration with others, demonstrate *skills* to:

- Use assessment and data collection methods to develop appropriate social-emotional, behavioral, and mental health goals for children with diverse abilities, disabilities, backgrounds, strengths, and needs

- Implement services to achieve outcomes related to socialization, learning, and mental health, including, for example, counseling, consultation, behavioral intervention, home-school collaboration, and other evidence-based practices
- Integrate behavioral supports and mental health services with academic and learning goals for children
- Use empirically supported strategies to develop and implement services at the individual, group, and/or systems levels and to enhance classroom, school, home, and community factors related to children's mental health, socialization, and learning
- Implement methods to promote intervention acceptability and fidelity and appropriate data-based decision making procedures, monitor responses of children to behavioral and mental health services, and evaluate the effectiveness of services

#### 2.5 Diversity in Development and Learning

School psychologists have *knowledge* of the following:

- Individual differences, abilities, disabilities, and other diverse characteristics of people in settings in which school psychologists work
- Psychological and educational principles and research related to diversity factors for children, families, and schools, including factors related to culture, individual, and role differences (e.g., age, gender or gender identity, cognitive capabilities, social-emotional skills, developmental level, race, ethnicity, national origin, religion, sexual and gender orientation, disability, chronic illness, language, socioeconomic status)
- Empirically supported strategies in psychology and education to enhance services for children and families and in schools and communities and effectively address potential influences related to diversity
- Strategies for addressing diversity factors in design, implementation, and evaluation of all services

School psychologists demonstrate *skills* to:

- Provide effective professional services in data-based decision making, consultation and collaboration, and direct and indirect services for individuals, families, and schools with diverse characteristics, cultures, and backgrounds, with recognition that an understanding of and respect for diversity and in development and learning is a foundation for all aspects of service delivery

- In collaboration with others, address individual differences, strengths, backgrounds, and needs in the design, implementation, and evaluation of services in order to improve academic, learning, social, and mental health outcomes for all children in family, school, and community contexts
- In schools and other agencies, advance social justice and recognition that cultural, experiential, linguistic, and other areas of diversity may result in different strengths and needs; promote respect for individual differences; recognize complex interactions between individuals with diverse characteristics; and implement effective methods for all children, families, and schools to succeed
- Provide culturally competent and effective practices in all areas of school psychology service delivery and in the contexts of diverse individual, family, school, and community characteristics

## 2.6 School-Wide Practices to Promote Learning

School psychologists have *knowledge* of the following:

- School and systems structure, school organization, general education, special education, and alternative educational services across diverse settings
- Psychological and educational principles and research related to organizational development and systems theory,
- Issues and needs in schools, communities, and other settings, including accountability requirements and local, state, and federal policies and regulations
- Empirically supported school practices that promote academic outcomes, learning, social development, and mental health; prevent problems; and ensure positive and effective school organization and climate across diverse situations, contexts, and characteristics

School psychologists, in collaboration with others, demonstrate *skills* to:

- Design and implement empirically supported practices and policies in, for example, areas such as discipline, instructional support, staff training, school improvement activities, program evaluation, student transitions at all levels of schooling, grading, home-school partnerships, etc.
- Utilize data-based decision making and evaluation methods, problem-solving strategies, consultation, and other services for systems-level issues, initiatives, and accountability responsibilities
- Create and maintain effective and supportive learning environments for children and others within a multitiered continuum of school-based services

- Develop school policies, regulations, services, and accountability systems to ensure effective services for all children

## 2.7 Preventive and Responsive Services

School psychologists have *knowledge* of the following:

- Psychological and educational principles and research related to resilience and risk factors in learning and mental health
- Methods of population-based service delivery in schools and communities to support prevention and timely intervention related to learning, mental health, school climate and safety, and physical well-being across diverse situations, contexts, and characteristics
- Universal, selected, and indicated (i.e., primary, secondary, and tertiary) prevention strategies at the individual, family, group, and/or systems levels related to learning, mental health, and physical well-being
- Empirically supported strategies for effective crisis prevention, preparation, and response

School psychologists, in collaboration with others, demonstrate *skills* to:

- Promote environments, contexts, and services for children that enhance learning, mental and physical well-being, and resilience through protective and adaptive factors and that prevent academic problems, bullying, violence, and other risks
- Use assessment and data collection methods to develop appropriate goals for and to evaluate outcomes of prevention and response activities and crisis services
- Contribute to, design, implement, and/or evaluate prevention programs that integrate home, school, and community resources and promote learning, mental health, school climate and safety, and physical well-being of all children and families
- Contribute to, design, implement, and/or evaluate services for crisis prevention, preparation, response, and recovery at the individual, family, and systems levels and that take into account diverse needs and characteristics
- Utilize data-based decision making methods, problem-solving strategies, consultation, collaboration, and direct and indirect services for preventive and responsive services to promote learning and mental health and for crisis services

## 2.8 Family-School Collaboration Services

School psychologists have *knowledge* of the following:

- Characteristics of families, family strengths and needs, family culture, and family-school interactions that impact children's development
  - Psychological and educational principles and research related to family systems and their influences on children's academic, motivational, social, behavioral, mental health, and social characteristics
  - Empirically supported strategies to improve outcomes for children by promoting collaboration and partnerships among parents, schools, and community agencies, and by increasing family involvement in education
  - Methods that improve family functioning and promote children's learning, social development, and mental health, including, for example, parent consultation, conjoint consultation, home-school collaboration, and other evidence-based practices
- School psychologists, in collaboration with others, demonstrate *skills* to:
- Design and implement empirically supported practices and policies that facilitate family-school partnerships and interactions with community agencies to enhance academic, learning, social, and mental health outcomes for all children
  - Identify diverse cultural issues, situations, contexts, and other factors that have an impact on family-school interactions and address these factors when developing and providing services for families
  - Utilize data-based decision making and evaluation methods, problem-solving strategies, consultation, and direct and indirect services to enhance family-school-community effectiveness in addressing the needs of children
  - Design, implement, and evaluate educational, support, and other types of programs that assist parents with promoting the academic and social-behavioral success of their children and addressing issues and concerns
- Techniques for judging research quality; synthesizing results across research relevant for services for children, families, and schools; and applying research to evidence-based practice
- School psychologists demonstrate *skills* to:
- Evaluate and synthesize a cumulative body of research and its findings as a foundation for effective service delivery
  - Provide assistance in schools and other settings for analyzing, interpreting, and using empirical foundations for effective practices at the individual, group, and/or systems levels
  - Incorporate various techniques for data collection, measurement, analysis, accountability, and use of technology resources in decision-making and in evaluation of services at the individual, group, and/or systems levels
  - In collaboration with others, design, conduct analyses, and/or interpret research and/or program evaluation in applied settings

## 2.10 Legal, Ethical, and Professional Practice

School psychologists have *knowledge* of the following:

- History and foundations of their profession
- Multiple school psychology service delivery models and methods
- Ethical and professional standards for school psychology
- Legal standards and regulations
- Factors related to professional identity in school psychology
- Relevant information sources and technology
- Methods for planning and engaging in continuing education

School psychologists demonstrate *skills* to:

- Provide services consistent with ethical and professional standards in school psychology
- Provide services consistent with legal standards and regulations
- Engage in effective ethical and professional decision-making that reflects recognition of diverse needs and characteristics of children, families, schools, and other professionals
- Apply professional work characteristics needed for effective practice as a school psychologist, including respect for human diversity and social justice, communication skills, effective interpersonal skills, responsibility, adaptability, initiative, and dependability
- Utilize supervision and mentoring for effective school psychology practice

## 2.9 Research and Program Evaluation

School psychologists have *knowledge* of the following:

- Research design, measurement, and varied methods of data collection techniques used in investigations of psychological and educational principles and practices
- Statistical and other data analysis techniques sufficient for understanding research and interpreting data in applied settings
- Program evaluation methods at the individual, group, and/or systems levels
- Technology and information resources applicable to research and program evaluation

- Engage in effective, collaborative professional relationships and interdisciplinary partnerships
- In collaboration with other professionals (e.g., teachers, principals, library and media specialists), access, evaluate, and utilize information resources and technology in ways that enhance the quality of services for children
- Advocate for school psychologists' professional roles to provide effective services, ensure access to their services, and enhance the learning and mental health of all children and youth
- Engage in career-long self-evaluation and continuing professional development

## DIAA ACUTE CONCUSSION EVALUATION (ACE) & RETURN TO PLAY FORM



Athlete Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sport: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Qualified HealthCare Provider (QHP) at school \_\_\_\_\_

Name of QHP initially examining athlete on site: \_\_\_\_\_ (please print)

Date initially examined: \_\_\_\_\_

Today the following symptoms are present (please circle):

No reported symptoms: \_\_\_\_\_

Physical	Thinking	Emotional	Sleep	
Headache	Light sensitivity	Feeling mentally foggy	Irritability	Drowsiness
Nausea	Noise sensitivity	Problems concentrating	Sadness	Sleeping more than usual
Fatigue	Numbness/tingling	Problems remembering	Feeling more emotional	Sleeping less than usual
Vomiting	Visual problems	Feeling slowed down	Nervousness	Trouble falling asleep
Dizziness	Balance problems			
OTHER: _____				

### Gradual Return to Play (RTP) Plan

RTP Plan must occur in gradual steps under the supervision of a QHP (see DIAA regulations for definition of QHP). This QHP, usually the schools ATC or RN, should be on-site supervising the RTP plan. After completion of a stage without any symptoms, athlete may progress to the next level of activity on the next day. If symptoms return, athlete must regress the stage and be seen by a qualified physician (see DIAA regs) if not seen by a MD/DO prior. Continued or worsening signs or symptoms should be reported to the physician immediately. **Before an athlete may initiate Stage 5 'full contact', they must be cleared by a qualified physician.**

School QHP Signature: \_\_\_\_\_

Date: \_\_\_\_\_

- Stage 1: No physical activity. If athlete has no signs or symptoms consistent with a concussion they may progress, after 24 hours, to Stage 2, etc.
- Stage 2: Low levels of physical activity (ie symptoms do not come back during or after the activity). This includes walking, light jogging, light stationary bike, light weight lifting ( low weight, higher reps, no bench, no squat)
- Stage 3: Moderate levels of physical activity with body/head movement. Includes moderate jogging, brief running, moderate-intensity stationary biking, moderate-intensity weightlifting (reduce time and/or weight from typical routine)
- Stage 4: Heavy non-contact physical activity. This includes sprinting/running, high intensity stationary bike, regular weightlifting routine, non-contact sport specific drills (3 planes of movement)
- Stage 5: **\*\*\* Must have physician clearance before beginning this stage\*\*\*** Full contact in controlled practice.
- Stage 6: Full contact in game play. If signs or symptoms return after Stage 5, must see physician again for Stage 6 clearance.

- ❖ **ATHLETES MAY NOT RETURN TO ACTIVITY ON THE SAME DAY THAT A HEAD INJURY OCCURRED**
- ❖ **ATHLETES MAY NOT RETURN TO ACTIVITY IF THEY EXHIBIT ANY SIGNS OR SYMPTOMS CONSISTENT WITH A CONCUSSION**
- ❖ **ATHLETES MUST SUCCESSFULLY PROGRESS THROUGH THE RTP PLAN, WITH MD/DO CLEARANCE, BEFORE CONTACT/RTP**

### PHYSICIAN CLEARANCE

I declare that I am a qualified physician (MD or DO only) who, in accordance with DIAA regulations as well as standards of medical care in concussion management, recommend the following:

- |  |   |
|--|---|
| May<br>check<br>more<br>than<br>one<br>box | <input type="checkbox"/> May not progress within the RTP Plan above; requires further medical intervention at this time. Contact my office<br><input type="checkbox"/> May resume gradual progression of the RTP Plan with the following exceptions/modifications: _____<br><input type="checkbox"/> May progress, per protocol, through Stage 5, and if symptom free, may advance to Stage 6.<br><input type="checkbox"/> Other: _____ |
|--|---|

This RTP Plan was based upon today's evaluation:

This form is adopted from the Acute Concussion Evaluation care plan developed by the CDC ([www.cdc.gov/injury](http://www.cdc.gov/injury)). All medical providers are strongly encouraged to use this form for concussed athletes participating in DIAA sports. While other forms may be used, all medical providers must abide by DIAA protocol ([http://www.doe.k12.de.us/infosultes/students\\_family/diaa/](http://www.doe.k12.de.us/infosultes/students_family/diaa/)) including the return to play plan noted above, before an athlete may return to athletics.



Physician's Name: \_\_\_\_\_ (please print) Physician's Office Phone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### INSTRUCTIONS FOR ACE FORM

1. If an athlete exhibits signs or symptoms consistent with a concussion, they shall be removed from play immediately. A qualified health care professional (QHP) must then determine whether or not an apparent concussion has occurred. If a qualified healthcare professional is not present, the injury must be treated as a concussion and the student not be allowed to return to practice/game until determined otherwise by a qualified healthcare professional. If the qualified healthcare professional is unable to rule out a concussion, the athlete must be treated as though he/she has sustained a concussion. The top (blue) section of the ACE form should be completed by the QHP, and the gradual RTP plan should be initiated. Note: in all situations where an athlete is determined to have a possible concussion, the athlete's parent or guardian should be contacted as soon as possible, and explained progressive warning signs as well as the RTP plan. If the symptoms become progressive, they should seek out physician services immediately.

2. The school's QHP may progress the athlete through the RTP plan (gold section) through stage four, so long as no symptoms return. Each stage of the RTP plan should be no less than one day long. If symptoms return, the athlete must be referred to a qualified physician (MD or DO only) before any further activity can occur. Before progressing to stage 5, the QHP must sign off on the RTP plan section of the form, and refer the athlete to a qualified physician (MD/DO only) if the athlete has not already seen a physician or if the physician requires such follow-up after an earlier physician visit.

3. Before progressing to stage 5, the school must obtain written clearance from a qualified physician (MD/DO only). This clearance can be found at the bottom (grey section) of the ACE form. Any athlete that progresses into stage 5 and beyond without written clearance shall be considered ineligible, and all games subsequent to such entry shall be a forfeit for the school.

A qualified healthcare professional (QHP) shall be defined as a MD or DO, or school nurse, nurse practitioner, physician assistant, or athletic trainer, with collaboration and/or supervision by a MD or DO as required by their professional state laws and regulations. The qualified healthcare professional must be licensed by their state, be in good standing with the State of Delaware, and if the evaluation is provided on site must also be approved or appointed by the administrative head of school or designee, or the DIAA Executive Director. "Written Clearance from a qualified physician" for progression into stage 5 and return to play after a potential concussion, shall be a MD/DO only, who is licensed by their state and in good standing with the State of Delaware.



AMERICAN  
SPEECH-LANGUAGE-  
HEARING  
ASSOCIATION

# Telepractice

## Overview



*Telepractice* is the application of telecommunications technology to the delivery of speech language pathology and audiology professional services at a distance by linking clinician to client/patient or clinician to clinician for assessment, intervention, and/or consultation.

Supervision, mentoring, and pre-service and continuing education are other activities that may be conducted through the use of technology. However, these activities are not included in ASHA's definition of telepractice and are best referred to as *telesupervision/distance supervision* and *distance education*. (See *Clinical Supervision in Speech-Language Pathology: Technical Report* [ASHA, 2008] for information related to the use of technology in clinical supervision in speech language pathology.)

ASHA adopted the term *telepractice* rather than the frequently used terms *telemedicine* or *telehealth* to avoid the misperception that these services are used only in health care settings. Other terms such as *teleaudiology* *telespeech*, and *speech teletherapy* may be used in addition to *telepractice*. Services delivered by audiologists and speech-language pathologists are also

included in the broader generic term *telerehabilitation* (American Telemedicine Association, 2010). The use of telepractice does not remove any existing responsibilities in delivering services, including adherence to the Code of Ethics, Scope of Practice in Audiology and Scope of Practice in Speech-Language Pathology, state and federal laws (e.g., licensure, HIPAA), and ASHA policy.

Telepractice venues include schools, medical centers, rehabilitation hospitals, community health centers, outpatient clinics, universities, clients'/patients' homes, residential health care facilities, childcare centers, and corporate settings. There are no inherent limits to where telepractice can be implemented, as long as the services comply with national, state, institutional, and professional regulations and policies.

The two most common terms describing types of telepractice are *synchronous* (client/patient interactive) and *asynchronous* (store and forward).

Synchronous services are conducted with interactive audio and video connection in real time to create an in-person experience similar to that achieved in a traditional encounter. Synchronous services may connect a client/patient or group of clients/patients with a clinician, or they may include consultation between a clinician and a specialist (Department of Health and Human Services, n.d., 2012).

In asynchronous services, images or data are captured and transmitted (i.e., stored and forwarded) for viewing or interpretation by a professional. Examples include transmission of voice clips, audiologic testing results, or outcomes of independent client/patient practice.

Hybrid applications of telepractice include combinations of synchronous, asynchronous, and/or inperson services. Clinicians and programs should verify state licensure and payer definitions to ensure that a particular type of service delivery is consistent with regulation and payment policies.

## Key Issues

## Resources

## References

**Content Disclaimer:** The Practice Portal, ASHA policy documents, and guidelines contain information for use in all settings; however, members must consider all applicable local, state and federal requirements when applying the information in their specific work setting.

## 4480. PERSONAL CARE SERVICES

A. General.--Effective November 11, 1997, HCFA published a final regulation in the Federal Register that removed personal care services from regulations at 42 CFR 440.170 and added a new section at 42 CFR 440.167, A Personal Care Services in a home or other location. @ The final rule specifies the revised requirements for Medicaid coverage of personal care services furnished in a home or other location as an optional benefit. This rule conforms to the Medicaid regulations and to the provisions of '13601(a)(5) of the Omnibus Budget Reconciliation Act (OBRA) of 1993, which added '1905(a)(24) to the Social Security Act to include payment for personal care services under the definition of medical assistance

Under '1905(a)(24) of the Act, States may elect, as an optional Medicaid benefit, personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR), or institution for mental disease. The statute specifies that personal care services must be: (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual=s family; and (3) furnished in a home or other location.

B. Changes Made by Final Regulation.--Personal care services may now be furnished in any setting except inpatient hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental disease. States choosing to provide personal care services may provide those services in the individual's home, and, if the State so chooses, in settings outside the home.

In addition, services are not required by Federal law to be provided under the supervision of a registered nurse nor does Federal law require that a physician prescribe the services in accordance with a plan of treatment. States are now permitted the option of allowing services to be otherwise authorized for the beneficiary in accordance with a service plan approved by the State.

\* C. Scope of Services.--Personal care services (also known in States by other names such as personal attendant services, personal assistance services, or attendant care services, etc.) covered under a State=s program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

1. Cognitive Impairments.--An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no

longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task properly.

2. Consumer-Directed Services.--A State may employ a consumer-directed service delivery model to provide personal care services under the personal care optional benefit to individuals in need of personal assistance, including persons with cognitive impairments, who have the ability and desire to manage their own care. In such cases, the Medicaid beneficiary may hire their own provider, train the provider according to their personal preferences, supervise and direct the provision of the personal care services and, if necessary, fire the provider. The State Medicaid Agency maintains responsibility for ensuring the provider meets State provider qualifications (see E below) and for monitoring service delivery. Where an individual does not have the ability or desire to manage their own care, the State may either provide personal care services without consumer direction or may permit family members or other individuals to direct the provider on behalf of the individual receiving the services.

D. Definition of Family Member.--Personal care services may not be furnished by a member of the beneficiary's family. Under the new final rule, family members are defined to be A legally responsible relatives. @ Thus, spouses of recipients and parents of minor recipients (including stepparents who are legally responsible for minor children) are included in the definition of family member. This definition necessarily will vary based on the responsibilities imposed under State law or under custody or guardianship arrangements. Thus, a State could restrict the family members who may qualify as providers by extending the scope of legal responsibility to furnish medical support.

E. Providers.--States must develop provider qualifications for providers of personal care services and establish mechanisms for monitoring the quality of the service. Services such as those delegated by nurses or physicians to personal care attendants may be provided so long as the delegation is in keeping with State law or regulation and the services fit within the personal care services benefit covered under a State's plan. Services such as assistance with taking medications would be allowed if they are permissible in States' Nurse Practice Acts, although States need to ensure the personal care assistant is properly trained to provide medication administration and/or management.

States may wish to employ several methods to ensure that recipients are receiving high quality personal care services. For example, States may opt to a criminal background check or screen personal care attendants before they are employed. States can also establish basic minimal requirements related to age, health status, and/or education and allow the recipient to be the judge of the provider's competency through an initial screening. States can provide training to personal care providers. States also may require agency providers to train their employees. States can also utilize case managers to monitor the competency of personal care providers. State level oversight of overall program compliance, standards, case level oversight, attendant training and screening, and recipient complaint and grievance mechanisms are ways in which States can monitor the quality of their personal care programs. In this way, States can best address the needs of their target populations and develop unique provider qualifications and quality assurance mechanisms.

members who are in DHCP are eligible to receive the DSHP benefit package except as described in Section 3.4.4 below.

3.4.2.2 The Contractor shall provide the following DSHP benefit package services as Medically Necessary (as defined in Section 3.4.5 of this Contract, below) and subject to the listed limitations herein.

Service	Limitations
Inpatient hospital services	
Inpatient behavioral health services in a general hospital; in a general hospital psychiatric unit; in a psychiatric hospital (including an institution for mental disease) for members over age 65 and under age 21; and in a private residential treatment facility (PRTF) for under age 21 (In lieu of inpatient behavioral health services in a general hospital or a general hospital psychiatric unit, the Contractor may, pursuant to Section 3.4.8 of this Contract, provide behavioral health services in alternative inpatient settings licensed by the State)	<ul style="list-style-type: none"> <li>For members age 18 and older (inpatient behavioral health services to members under age 18 are provided by DSCYF)</li> </ul>
Outpatient hospital services, including emergency rooms	
Behavioral health crisis intervention services, including facility-based crisis services and mobile crisis teams	<ul style="list-style-type: none"> <li>30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF)</li> </ul>
Pharmacy including physician administered drugs	<ul style="list-style-type: none"> <li>Pharmacy does not include Medication Assisted Treatment (MAT) for substance use disorders (SUDs); MAT is included in the SUD benefit below</li> </ul>
Clinic services including ambulatory surgical centers and end stage renal disease clinics	
Federally Qualified Health Center services	
Substance use disorder services, including all levels of the American Society of Addiction Medicine (ASAM), Medication Assisted Treatment (MAT) and licensed opioid treatment programs	<ul style="list-style-type: none"> <li>30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF)</li> <li>For members participating in PROMISE, these services, except for medically managed intensive inpatient detoxification, are the responsibility of the State and paid through the State's MMIS</li> </ul>

Service	Limitations
Licensed behavioral health practitioner services, including licensed psychologists, clinical social workers, professional counselors and marriage and family therapists	<ul style="list-style-type: none"> <li>• 30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF)</li> <li>• For members participating in PROMISE, these services are the responsibility of the State and paid through the State's MMIS</li> </ul>
Laboratory and radiology services, including invasive and non-invasive imaging	
Nursing facility services	<ul style="list-style-type: none"> <li>• Up to 30 calendar days, then services are covered by the Contractor as part of the DSHP Plus LTSS benefit package</li> </ul>
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including periodic preventive health screens and other necessary diagnostic and treatment services for members under age 21	
Preventive services, including the services specified in 45 CFR 147.30	
Outpatient behavioral health services for members under age 18, including assessment, individual/ family/group therapy, crisis intervention, intensive outpatient and behavioral health rehabilitative services for children	<ul style="list-style-type: none"> <li>• For members under age 18</li> <li>• 30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF)</li> <li>• See Appendix 1</li> </ul>
Family planning services (including voluntary sterilization if consent form is signed after member turns age 21)	
Physician services, including certified nurse practitioner services	<ul style="list-style-type: none"> <li>• For members participating in PROMISE, the following physician oversight and direct therapy that is considered to be a part of the following PROMISE services are included in the PROMISE rates and paid FFS through the State's MMIS: Assertive Community Treatment (ACT) services, Intensive Case Management (ICM) services, and supervision of group home services</li> </ul>
Administrative fee for vaccines to children	
Podiatry services	
Optometry/optician services	
Home health services	

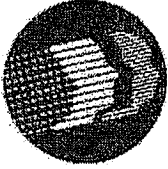
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3.4.3.4 The Contractor shall provide the following long term services and supports to DSHP Plus LTSS members when the services have been determined by the Contractor to be Medically Necessary:

Service	Definition/Limitation
Nursing facility services	The services provided by a nursing facility to residents of the facility, including skilled nursing care and related services, rehabilitation services, and health-related care and services.
Community-based residential alternatives that include assisted living facilities	<ul style="list-style-type: none"> <li>• Community-based residential services offer a cost-effective, community based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes assisted care living facilities. Community-based residential services include personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to participants who reside in a homelike, non-institutional setting. Assisted living includes a 24-hour onsite response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). As needed, this service may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors. Services that are provided by third parties must be coordinated with the assisted living provider. Personal care services are provided in assisted living facilities as part of the community-based residential service. To avoid duplication, personal care (as a separate service) is not available to persons residing in assisted living facilities.</li> </ul>
* Attendant care services	<ul style="list-style-type: none"> <li>• Attendant care services includes assistance with ADLs (bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility).</li> <li>• Not available to persons residing in assisted living or nursing facilities.</li> </ul>





**DELAWARE HEALTH  
AND SOCIAL SERVICES**

DIVISION OF  
MEDICAID & MEDICAL ASSISTANCE

TELEPHONE: (302) 255-9500

August 26, 2015

Laura J. Waterland, Esq.  
Disabilities Law Program  
Community Legal Aid Society, INC  
100 W. 10<sup>th</sup> Street, Suite 801  
Wilmington, DE 19801

Dear Ms. Waterland:

Thank you for your correspondence of July 29, 2015. The comments you provided regarding changes to the Private Duty Nursing Provider Specific Policy Manual are greatly appreciated. DMMA has reviewed your comments/suggestions and will take the following actions:

1. Section 1.0 discusses the application of this regulation. It is difficult, however, to determine the scope of application of the policy. On the one hand, the second sentence indicates that MCOs are required, at a minimum, to provide coverage described in the policy. On the other hand, specific standards sometimes refer exclusively to the State (e.g. §5.1.1 requiring prior authorization by DMAP; §5.2.2 contemplating DMMA revision of hours) and sometimes refers to both the State and MCOs (e.g. §5.2.7). This is confusing. DMMA may wish to adopt more uniform language related to the State and MCOs in the body of the regulation. DMMA may also wish to clarify that the policy is not the exclusive source of standards, i.e., the DMMA-MCO contract (which is updated annually) is also applicable. Consider the following revision:

*"An MCO is required to provide, at a minimum, coverage of services described in this Policy. The MCO's contract with DMMA may include additional obligations."*

**Response:**

DMMA agrees with DLP's suggested revision. Changes will be made as follows:

Effective July 1, 2007, Private Duty Nursing (PDN) services are provided to the majority of Medicaid individuals through a Managed Care Organization (MCO). MCOs are required to provide, at a minimum, coverage of services described in this provider specific policy manual. The MCO's contract with DMMA may include additional obligations. Services provided to individuals enrolled in a MCO are not billed to the Delaware Medical Assistance Program (DMAP).

2. Section 1.1.4 generally limits PDN to situations where it is less expensive than institutional care. This should be reconsidered. First, this restriction may violate the ADA, which disallows institutional placement based on "rigid" financial justification. If PDN care cost \$1 more than

institutional care, that should not justify loss of community living. Second, Delaware Medicaid waivers predominantly adopt an aggregate cost, not individual cost, approach. Third, The DSHP Plus program is designed to "encourage" MCOs to favor non-institutional care. The DHSS DSHP+ Waiver Amendment Request confirms that "the MCO will be expected to emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible" [emphasis supplied] (Excerpt-Attachment A). Adopting an individual cost cap approach undermines this public policy and will prompt MCOs to not prioritize community living (e.g., covered children will be relegated to nursing homes).

**Response:**

The inclusion of the word "generally" indicates that this is not a "rigid" requirement. DMMA considers a variety of factors, including cost, in the determination of appropriateness of services for our members with an emphasis on the importance of preventing or delaying institutionalization. An individual cost cap is not imposed. We do not believe a revision is required in this instance.

3. Section 4.1.1 Mandates that DMAP establish a maximum weekly limit for each individual. For clarity, consider the following alternate sentence:

*"The number of weekly hours of PDN services authorized for each individual will be based on an individual's needs and documented in the plan of care."*

**Response:**

DMMA agrees with CLASI's suggestion. Section 4.1.1 will be revised as follows:

Private duty nursing services provided to eligible DMAP individuals are reimbursed using prospectively determined rates. The unit of service for agency providers is one (1) hour. The number of weekly hours of PDN services authorized for each individual will be based on the individual's needs and documented in the plan of care.

4. Section 5.2.2 authorizes a reduction in PDN hours solely based on medical necessity. This is contrary to case law which requires a change in circumstances (e.g. medical improvement; new assistive technology) to justify a reduction. See, e.g., In re S.E., DCIS No. 7000870073 (DHSS December 17, 2013) [proposed reduction of personal care services denied since MCO did not show both change in condition and conformity with medical necessity criteria] (Attachment B); and In re J.B., First State ID 000337988\*01 (DHSS October 19, 2001) [proposed reduction of PT denied since MCO did not demonstrate change in circumstances or other good cause] (Attachment C). We recommend amending the second sentence in §5.2.2 as follows:

*"DMMA may determine that PDN hours may be increased based on medical necessity or reduced based on medical necessity accompanied by change in circumstances or other good cause."*

**Response:**

DMMA agrees with CLASI's suggestion. Section 5.2.2 will be revised as follows:

The on-going need for PDN care is routinely/periodically re-evaluated. DMMA may determine that PDN hours may be increased based on medical necessity or reduced based on medical necessity accompanied by a change in circumstances or other good cause.

- 5., Section 5.2.3 requires a caretaker or parent to accept responsibility for care before PDN can be authorized. This provision should be revised. First, PDN is categorically barred unless an individual has a parent or caregiver to cover when a nurse is not "available." As a result, individuals who are the neediest, with the most fragile support system, cannot benefit from PDN services. In contrast, the DSAAPD PAS Service Specifications require the responsible agency to include a backup component in the service plan. See PAS Service Specifications §§3.2.4 and 3.2.5 (Attachment D). MCOs should be expected to include a backup component in the plan of care "when the nurse is not available."

Second, the recitation that "DMMA expects that parents...be willing and capable to accept responsibility for the individual's care" has no legal basis in the context of adult beneficiaries.

Third, there may be cases in which the PDN is relatively limited (e.g. 4 hours/day) and the beneficiary is capable of self-care for the balance of time. Literally, such an individual is barred from receiving PDN since he/she lacks an (unnecessary) caregiver.

Fourth, there may be circumstances in which an individual receives both PDN and personal care services from home health aides or both PDN and PPEC (Nurses & Kids) services. Indeed, this is contemplated by §5.3.5. Literally construed, §5.2.3 would categorically require the parent/caregiver to be present when personal care services or PPEC services are provided.

**Response:**

The words parent and parents will be removed since this policy covers PDN for adults and children. Reference will be made to 'caregivers', they may or may not be parents.

DMMA disagrees that the language in this section bars the neediest individuals with the most fragile support systems from receiving PDN. In order to provide a safe environment, a caregiver must be available to those individuals that are incapable of self-care.

Individuals who are capable of self-care must still have a back-up plan of supports in order to ensure their safety and the continuity of medical care outside of PDN authorized hours.

PDN is meant to support other formal and informal services that are in place. It is not meant to be the primary supportive service for individuals.

Section 5.2.3 will be revised as follows:

PDN services will only be authorized when there is at least one caregiver willing and able to accept responsibility for the individual's care when the nurse is not available. DMAP expects

that caregivers be willing and capable to accept responsibility for the individual's care. If the caregiver cannot or will not accept responsibility for the individual's care when PDN services are not authorized or available, the individual is deemed not to be in a safe environment and PDN services will not be authorized.

6. Section 5.2.5, which covers PDN services when a beneficiary is being transported, is too brittle and also not practical. There are situations in which a parent is willing to accompany a child but not capable of providing necessary medical care (e.g. suctioning; seizure intervention), or, in circumstances when the parent is driving, where the parent is not capable of providing the necessary care while transporting the child to and from the appointment. Further, this section would categorically bar nurse accompaniment if a parent is physically present, whether the child needs additional assistance or not. Thus, if a seizure prone child is transported for a dental appointment, the nurse must depart and the child is placed at risk. PDN services should be provided for transportation when medically necessary, as determined on an individualized basis. We recommend deleting the following sentence:

*"If the individual is transported to a medical appointment or the hospital with the PDN, as soon as the parent/caregiver arrives, the PDN is no longer required."*

**Response:**

DMMA agrees with this suggestion. Section 5.2.5 will be revised as follows:

DMA P reimburses for medically necessary transportation through a Medicaid transportation broker. PDN services will be authorized for transportation when medically necessary, as determined on an individualized basis.

7. Section 5.2.6 covers PDN services at school. Parental consent is an easily overlooked federal requirement for the provision of Medicaid-funded services in schools. (Attachment E). The first sentence should be amended as follows:

*"If DMMA determines...during the school day with parental consent."*

**Response:**

Section 5.2.6 will be revised as follows:

PDN services may be authorized during the school day with parental consent, as indicated by the agreement with the child's Individual Education Plan (IEP), if DMA P determines that a school is unable to meet the medical needs of school age children who are technology dependent or for whom DMA P has determined these services to be otherwise medically necessary. This may include accompanying the children during the transport to and from school and providing medically necessary care during school hours.

8. In Section 5.2.7, it is anomalous to require prior approval for an "unplanned school closure" or other unforeseen event (e.g. sudden illness). We suggest amending the second sentence as follows:

*"However, additional hours must be prior authorized whenever possible."*

Alternatively, you may wish to add a requirement that families call in to DMAP or the MCO as soon as possible to report the unforeseen need.

**Response:**

DMMA agrees that requiring 'prior' approval for an 'unplanned school closure' is incongruous. Please note that this section already requires that caregivers contact DMMA or the MCO as soon as they know of an unplanned closure.

Section 5.2.7 will be revised as follows:

PDN services may be approved when a child is home sick with a cold, virus or normal childhood disease or there are unplanned school closures or inclement weather days. However, additional hours must be authorized. Home health agencies may not be able to provide "on demand or same day service." Parents/caregivers should contact DMMA or their MCO as soon as they know about an unplanned school closure, etc.

9. Section 5.3.1 outlines how hours provided are calculated, including a phase in period for technology-dependent patients. We suggest that this section be amended to cover people with high risk conditions, in addition to technology-dependent individuals. It is also unclear whether the 20 hours is a maximum cap for PDN. Again, it is important to state that medical necessity is assessed on an individualized basis.

**Response:**

DMMA has considered CLASI's comments. Section 5.3.1 will be revised as follows:

PDN services may be approved for up to 24 hours per day for up to three to four (3-4) days when medically necessary to help caregivers adjust and ensure all equipment is functioning following a transition or discharge from a hospital or other facility to the community. Once the transition is successfully accomplished, PDN services would be gradually reduced based upon individually assessed medical necessity.

10. Section 5.3.2 adds a provision regarding providing hours to avoid institutionalization. The word "increase" suggests that there is a cap (though no cap is clearly set in 5.3.1). Second, consistent with our comments in 1.1.4, overemphasis on cost is not appropriate. Consider the following substitute for the first sentence:

*Federal and State policy encourages provision of covered services to enable individuals to remain in the community. In determining the scope of PDN services, additional hours may be authorized to avoid hospital or institutional placement.*

Finally, we recommend substituting "prescribing physician" or "treating physician" for "admitting physician" since PDN is being provided in non-institutional settings.

**Response:**

DMMA has considered CLASI's comments. Section 5.3.2 will be revised as follows:

An increase in hours may be approved if additional hours will avoid hospitalization or institutional placement. This will depend on the medical necessity, the amount of additional hours needed and the letter of medical necessity from the individual's primary care physician (PCP).

11. Section 5.3.3 allows additional nighttime hours for sleep. We wonder whether this section regarding sleep coverage is necessary given that Section 5.3.1 indicates that PDN services are determined on the basis of medical necessity, provided of course that medical necessity reflects the actual availability of caretakers/parents to provide care. If the parents and caretakers are sleeping, then they are not available to provide care (see comments below on Section 5.3.4).

**Response:**

DMMA has considered CLASI's comments and has decided that section 5.3.3 needs to remain in the manual. This section addresses a specific issue for DMMA. Our goal with including this specific language is to make it clear that even if a caregiver is not working and is available at night to provide care, they should still be able to receive PDN in order to sleep so that they can continue to be mentally and physically prepared to care for the individual in the home.

12. Section 5.3.4 allows adjustment of PDN hours based on availability of caretakers/parents. We suggest that the regulation include some guidance on what "availability" means. Caretaker/parent sleep needs, parenting demands for other children, work needs, health needs and limitations and skill levels are all relevant aspects of availability. It is worth noting that the new CMS regulations on person-centered planning makes clear that natural unpaid supports must be voluntary, and DMMA and the MCOs cannot presume "availability." (Attachment F) Consider the following one sentence standard:

*"Availability" is individually determined based on a totality of circumstances, including the following:*

- 1) *Parental/caretaker health and capabilities;*
- 2) *Profiles and needs of other family members;*
- 3) *Employment and education schedules and responsibilities;*
- 4) *Reasonable opportunities to sleep, shop, run errands, participate in health maintenance or fitness activities, and engage in normal activities of daily living.*

**Response:**

DMMA has considered CLASI's comments. PDN is a service that may be authorized in support of the self-care/care services that are provided by a caregiver or through self-care to an individual on Medicaid. PDN is not meant to be used as the primary mechanism through which medical care should be administered to the individual and it should not be authorized solely for the

convenience of the individual and/or the individual's family/caregiver. DMMA agrees to revise section 5.3.4 as follows:

PDN may be adjusted based on the availability of the parent/caregiver as determined by DMAP. "Availability" is individually determined based on a totality of circumstances. DMAP requires that documentation of parent/caregiver unavailability be provided annually, or when/if change occurs.

Thank you again for your review and feedback related to the changes in the DMAP PDN manual. Please feel free to contact me if you have any questions and or concerns.

Sincerely,

A handwritten signature in cursive script that reads "Lisa Zimmerman".

Lisa Zimmerman  
Deputy Director  
Division of Medicaid & Medical Assistance  
Delaware Health and Social Services

## **ALERT**

# **HCFA Letter Regarding Individuals with Disabilities**

On the anniversary of the ADA, Sally Richardson, Director of Medicaid and State Operations for HCFA has issued a letter to State Medicaid Directors informing them that states, including the state Medicaid agency, have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs. The letter summarizes three decisions under the Americans with Disabilities Act: *L.C. & E.W. v. Olmstead*, *Helen L. V. Didario* and *Easley v. Snider*, and directs states to undertake and complete the self-evaluation required by the law "to ensure that the state's policies, practices and procedures promote, rather than hinder integration. The letter closes by urging states to "strive to meet the objectives [of the law] by continuing to develop home and community-based service options for persons with disabilities to live in integrated settings." The letter in its entirety is reproduced below.



### **DEPARTMENT OF HEALTH & HUMAN SERVICES** **Health Care Financing Administration**

---

**Center for Medicaid and State Operations**  
**7500 Security Boulevard**  
**Baltimore, MD 21244-1850**

July 29, 1998

Dear State Medicaid Director:

In the Americans with Disabilities Act (ADA), Congress provided that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." 42 U.S.C. § 12101(a)(8). Title II of the ADA further provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be the subject of discrimination by any such entity." 42 U.S.C. § 12132. Department of Justice regulations implementing this provision require that "a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

We have summarized below three Medicaid cases related to the ADA to make you aware of recent trends involving Medicaid and the ADA.

In *L.C. & E.W. v. Olmstead*, patients in a State psychiatric hospital in Georgia challenged their placement in an institutional setting rather than in a community-based treatment program. The United States Court of Appeals for the Eleventh Circuit held that placement in an institutional setting appeared to violate the ADA because it constituted a segregated setting, and remanded the case for a determination of whether community placements could be made without



fundamentally altering the State's programs. The court emphasized that a community placement could be required as a "reasonable accommodation" to the needs of disabled individuals, and that denial of community placements could not be justified simply by the State's fiscal concerns. However, the court recognized that the ADA does not necessarily require a State to serve everyone in the community but that decisions regarding services and where they are to be provided must be made based on whether community-based placement is appropriate for a particular individual in addition to whether such placement would fundamentally alter the program.

In *Helen L. v. DiDario*, a Medicaid nursing home resident who was paralyzed from the waist down sought services from a State-funded attendant care program which would allow her to receive services in her own home where she could reside with her children. The United States Court of Appeals for the Third Circuit held that the State's failure to provide services in the "most integrated setting appropriate" to this individual who was paralyzed from the waist down violated the ADA, and found that provision of attendant care would not fundamentally alter any State program because it was already within the scope of an existing State program. The Supreme Court declined to hear an appeal in this matter; thus, the Court of Appeals decision is final. Page 2 - State Medicaid Director

In *Easley v. Snider*, a lawsuit, filed by representatives of persons with disabilities deemed to be incapable of controlling their own legal and financial affairs, challenged a requirement that beneficiaries of their State's attendant care program must be mentally alert. The Third Circuit found that, because the essential nature of the program was to foster independence for individuals limited only by physical disabilities, inclusion of individuals incapable of controlling their own legal and financial affairs in the program would constitute a fundamental alteration of the program and was not required by the ADA. This is a final decision.

While these decisions are only binding in the affected circuits, the Attorney General has indicated that under the ADA States have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs. Reasonable steps should be taken if the treating professional determines that an individual living in a facility could live in the community with the right mix of support services to enable them to do so. The Department of Justice recently reiterated that ADA's "most integrated setting" standard applies to States, including State Medicaid programs.

States were required to do a self-evaluation to ensure that their policies, practices and procedures promote, rather than hinder integration. This self-evaluation should have included consideration of the ADA's integration requirement. To the extent that any State Medicaid program has not fully completed its self-evaluation process, it should do so now, in conjunction with the disability community and its representatives to ensure that policies, practices and procedures meet the requirements of the ADA. We recognize that ADA issues are being clarified through administrative and judicial interpretations on a continual basis. We will provide you with additional guidance concerning ADA compliance as it becomes available.

I urge you also, in recognition of the anniversary of the ADA, to strive to meet its objectives by continuing to develop home and community-based service options for persons with disabilities to live in integrated settings.

If you have any questions concerning this letter or require technical assistance, please contact Mary Jean Duckett at (410) 786-3294.

Sincerely,

/s/

Sally K. Richardson  
Director

cc: All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations Page 3 - State  
Medicaid Director

Lee Partridge  
American Public Human Services Association

Joy Wilson  
National Conference of State Legislatures

Jennifer Baxendell  
National Governors' Association


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## ALERT

**HCFA Dear State Medicaid Director Letter Provides Guidance  
on *Olmstead* Decision Regarding Individuals with Disabilities**

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Health Care Financing Administration**
**Center for Medicaid and State Operations**
**7500 Security Boulevard**
**Baltimore, MD 21244-1850**

January 14, 2000

Dear State Medicaid Director:

The recent Supreme Court decision in *Olmstead v. L.C.*, 119 S.Ct. 2176 (1999), provides an important legal framework for our mutual efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs. The Court's decision clearly challenges us to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services.

This decision confirms what this Administration already believes: that no one should have to live in an institution or a nursing home if they can live in the community with the right support. Our goal is to integrate people with disabilities into the social mainstream, promote equality of opportunity and maximize individual choice.

The Department of Health and Human Services (DHHS) is committed to working with all affected parties to craft comprehensive, fiscally responsible solutions that comply with the Americans with Disabilities Act of 1990 (ADA). Although the ADA applies to all State programs, Medicaid programs play a critical role in making community services available. As a consequence, State Medicaid Directors play an important role in helping their States comply with the ADA. This letter conveys our initial approach to *Olmstead* and outlines a framework for us to respond to the challenge.

*The Olmstead Decision*

The *Olmstead* case was brought by two Georgia women whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs lived in State-run institutions, despite the fact that their treatment professionals had determined that they could be appropriately served in a community setting. The plaintiffs asserted that continued institutionalization was a violation of their right under the ADA to live in the most integrated

setting appropriate. The *Olmstead* decision interpreted Title II of the ADA and its implementing regulation, which obliges States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." (28 CER 35.130(d)). In doing so, the Supreme Court answered the fundamental question of whether it is discrimination to deny people with disabilities services in the most integrated setting appropriate. The Court stated directly that "Unjustified isolation. . . is properly regarded as discrimination based on disability." It observed that (a) "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated

Page 2 - State Medicaid Director -----

are incapable or unworthy of participating in community life," and (b) "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Under the Court's decision, States are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the State's treatment professionals reasonably determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (C) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services. The Court cautioned however, that nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings. Moreover, the State's responsibility, once it provides community based treatment to qualified persons with disabilities, is not unlimited.

Under the ADA, States are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity." (28 CFR 35.130(b)(7)). The Supreme Court indicated that the test as to whether a modification entails "fundamental alteration" of a program takes into account three factors; the cost of providing services to the individual in the most integrated setting appropriate; the resources available to the State; and how the provision of services affects the ability of the State to meet the needs of others with disabilities. Significantly, the Court suggests that a State could establish compliance with title II of the ADA if it demonstrates that it has:

- a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and
- a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.

#### *Olmstead and the Medicaid Program*

*Olmstead* challenges States to prevent and correct inappropriate institutionalization and to review intake and admissions processes to assure that persons with disabilities are served in the most integrated setting appropriate. Medicaid can be an important resource to assist States in

meeting these goals, We want to work closely with States to make effective use of Medicaid support in your planning and implementation *Olmstead*. As an example of the interface between *Olmstead's* explanation of the State's ADA obligation and your Medicaid program we would point to the State's responsibility, under Medicaid, to periodically review the services of all residents in Medicaid-funded institutional settings. Those reviews may provide a useful

Page 3 - State Medicaid Director -----

component of the State's planning for a comprehensive response to *Olmstead*. States must also be responsive to institutionalized individuals who request that their situation be reviewed to determine if a community setting is appropriate. In such a case the State has a duty to redress the situation, subject to the limits outlined by the Court and the ADA. As another example, States may choose to utilize their Medicaid funds to provide appropriate services in a range of settings from institutions to fully integrated community support.

### *Comprehensive, Effectively Working Plans*

As we have noted, the Supreme Court in *Olmstead* indicated that a State may be able to meet its obligation under the ADA by demonstrating that it has a comprehensive, effectively working plan for placing qualified persons with disabilities in the most integrated setting appropriate, and a waiting list that moves at a reasonable pace not controlled by a State's objective of keeping its institutions fully populated. The Department believes that comprehensive, effectively working plans are best achieved with the active involvement of individuals with disabilities and their representatives in design, development and implementation.

The Court's *Olmstead* decision regarding the integration requirement applies to all individuals with disabilities protected from discrimination by title II of the ADA. Although *Olmstead* involved two individuals with mental disabilities, the scope of the ADA is not limited only to such individuals, nor is the scope of *Olmstead* limited to Medicaid beneficiaries or to services financed by the Medicaid program. In addition, the requirement to provide services in the most integrated setting appropriate applies not only to persons already in institutional settings but to those being assessed for possible institutionalization.

The enclosure to this letter offers some recommendations about key principles and practices for States to consider as they develop plans. We recognize that there is no single plan that is best suited for all States, and accordingly that there are many ways to meet the requirements of the ADA. We certainly hope States and people with disabilities will expand and improve on these ideas. Although these plans encompass more than just the Medicaid program, we realize the important role played by State Medicaid Directors in this area. As just one example, Federal financial participation will be available at the administrative rate to design and administer methods to meet these requirements, subject to the normal condition that the changes must be necessary for the proper and efficient administration of the State's Medicaid program. Because of your significant role, we have taken this opportunity to raise these issues with you.

The principles and practices contained in the accompanying technical assistance enclosure also serve as an important foundation for the DHHS Office for Civil Rights' (OCR) activities in this area. As you know, OCR has responsibility for investigating discrimination complaints involving the most integrated setting issue. OCR also has authority to conduct compliance

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reviews of State programs and has already contacted a number of States to discuss complaints. OCR strongly desires to resolve these complaints through collaboration and cooperation with all interested parties.

*Next Steps for the Department of Health and Human Services*

Consultation- We have begun consultation with States (including State Medicaid Directors and members of the long term care technical advisory group, who share responsibility for Medicaid) and with people with disabilities. We look forward to building on this start. Many States have made great strides toward enabling individuals with disabilities to live in their communities. There is much that we can learn from these States. We are interested in your ideas regarding the methods by which we might accomplish such continuing consultation effectively and economically.

Addressing Issues and Questions Regarding *Olmstead* and Medicaid: As we move forward, we recognize that States may have specific issues and questions about the interaction between the ADA and the Medicaid program. In response to the issues and questions we receive, we will review relevant federal Medicaid regulations, policies and previous guidance to assure that they (a) are compatible with the requirements of the ADA and the *Olmstead* decision, and (b) facilitate States' efforts to comply with the law.

Technical Assistance: In response to any issues raised by the States, the DHHS working group will develop a plan to provide technical assistance and information sharing among States and stakeholders. Responses to questions and technical assistance materials will be published on a special website. We are also funding projects in a number of States to assist with nursing home transition. Finally, we seek your ideas on the additional focus of technical assistance you would find most helpful for home and community-based services and conferences for State policy makers. We will use your suggestions to facilitate the implementation of the integration requirement. We invite all States and stakeholders to submit questions and recommendations to our departmental workgroup co-chaired by the Director of HCFA's Center for Medicaid and State Operations and the Director of the DHHS Office for Civil Rights. Please send such written correspondence to:

DHHS Working Group for ADA/*Olmstead*  
c/o Center for Medicaid and State Operations  
HCFA, Room S2- 14-26. DEHPG  
7500 Security Blvd.  
Baltimore, MD 21244-1850

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*Conclusion*

The Administration and DHHS have a commitment to expanding home and community-based services and offering consumers choices in how services are organized and delivered. Over the past few years, DHHS has focused on expanding and promoting home and community-based

services, offering support and technical assistance to States, and using the flexibility of the Medicaid program. The *Olmstead* decision affirms that we are moving in the right direction and we intend to continue these efforts.

We recognize that this interim guidance leaves many questions unanswered; with your input, we expect to develop further guidance and technical assistance. We recommend that States do the following:

- Develop a comprehensive, effectively working plan (or plans) to strengthen community service systems and serve people with disabilities in the most integrated setting appropriate to their needs;
- Actively involve people with disabilities, and where appropriate, their family members or representatives, in design, development and implementation;
- Use the attached technical assistance material as one of the guides in the planning process; .
- Inform us of questions that need resolution and of ideas regarding technical assistance that would be helpful.

We look forward to working with you to improve the nation's community services system.

Sincerely,

/s/

Timothy M. Westmoreland  
 Director  
 Center for Medicaid and State Operations  
 Health Care Financing Administration

/s/

Thomas Perez Director  
 Office for Civil Rights

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cc:

All HCFA Regional Administrators

All HCFA Associate Regional Administrators  
 Division of Medicaid and State Operations

American Public Human Services Association

National Association of State Directors of Developmental Disabilities Services

# The ADA, Olmstead, and Medicaid: Implications for People with Intellectual and Developmental Disabilities

By

Charles R. Moseley, Ed.D.

2013

**NASDDDS**

National Association of State Directors of Developmental Disabilities Services

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## The Americans with Disabilities Act and the Olmstead Ruling

The preference in federal policy for home and community-based services for persons with disabilities was advanced by the U.S. Supreme Court's ruling in 1999 in the case of *Olmstead v. L.C.* (527 U.S. 581 Amended 2008 (P.L. 110-325)). The Olmstead decision established that the unnecessary segregation of people with disabilities in institutions is a form of discrimination under Title II of the Americans with Disabilities Act of 1990 (ADA) and set the responsibility of states to provide services to individuals with disabilities within "the most integrated setting" appropriate to their needs. An executive order signed by President Bush in 2001 launched the "New Freedom Initiative" affirming the nation's commitment to the provision of publicly financed community-based services and supports to individuals with disabilities fostering independence and community participation. The federal government's commitment to assure the right of people with disabilities to live, work and receive services in community settings was renewed by President Obama when he declared 2009 to be "The Year of Community Living" and directed the Department of Justice (DOJ) and other federal agencies to "vigorously enforce the civil rights of Americans with disabilities" by ensuring the implementation of the Olmstead ruling as a top priority.<sup>1</sup>

### The Americans with Disabilities Act of 1990

**Background.** The Americans with Disabilities Act (ADA) was signed into law by President H. W. Bush on July 26, 1990. The landmark legislation was passed by Congress to "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities"<sup>2</sup> Noting that the historical isolation and segregation of people with disabilities continued to be "a serious and pervasive social problem,"<sup>3</sup> Congress acted to prohibit such discrimination by any public entity through the enactment of legislation that ensured that no qualified individual with a disability would, "... by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."<sup>4</sup>

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<sup>1</sup> U.S. Department of Justice. Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* Accessed from [www.ada.gov/olmstead/q&a\\_olmstead.pdf](http://www.ada.gov/olmstead/q&a_olmstead.pdf) November 2012.

<sup>2</sup> 42 U.S.C. § 12101(a)(2).

<sup>3</sup> 42 U.S.C. § 12101(b)(1).

<sup>4</sup> 42 U.S.C. § 12132.

The framework of the ADA was built upon several major pieces of legislation that were passed by the U.S. Congress during the 1960s and 1970s including the Civil Rights Act of 1964, the Voting Rights Act of 1965, the Civil Rights Act of 1968, and the Rehabilitation Act of 1973.

- The Civil Rights Act of 1964 prohibited discrimination by entities receiving public funds, employers, public facilities, and others based on race, religion, and national origin but did not specifically identify people with disabilities as a protected class.
- The Voting Rights Act of 1965 protects the rights of minorities to vote in elections but did not ensure the rights of people with disabilities.
- The Fair Housing Act, Title VIII of the Civil Rights Act of 1968, includes provisions that prohibit discrimination on the basis of race, religion, national origin, and sex in the sale and rental of housing, but it was not until 1988 that the act was amended to afford protections to people with disabilities and families with children.
- Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of a disability towards otherwise qualified people with disabilities by recipients of federal financial assistance. The legislation represents the first time that people with disabilities as a group were identified as a separate class – rather than as separate diagnoses.<sup>5</sup> No protections, however, were afforded for people with disabilities from discrimination by employers, by public accommodations in the private sector, by publicly funded programs and by those providing federal financial assistance.

Although each of these measures addressed significant civil rights issues, and had some impact on people with disabilities, none were specifically designed nor intended to address the barriers to full inclusion faced by people with disabilities in U.S. society. In its review of the need for legislation in this area Congress noted several national research findings on the status of people with disabilities in the U.S., and the challenges they faced in fully accessing and participating in the mainstream of community life. Congress found that more than 50 million Americans had one or more physical or mental disabilities, and the prevalence rate was increasing as the nation's population

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<sup>5</sup> Mayerson, A. (1992) *The History of the ADA: A Movement Perspective*. Disability Rights Education and Defense Fund, Berkeley CA.

grew. It was also noted that discrimination on the basis of a person's disability existed throughout American society in housing, public accommodations, education, transportation, communication, recreation, health services, voting, and access to public services. Furthermore, in contrast to the experiences of individuals who faced discrimination on the basis of race, color, sex, origin, religion, or age, people with disabilities were not as a class generally covered by existing civil rights legislation and often had no remedy in the law to redress such discrimination. Congress noted that the continuing existence of unfair and unnecessary discrimination and prejudice denied people with disabilities the opportunity to compete and pursue opportunities on an equal basis with the non-disabled population, and that the costs of discrimination in terms of national expenditures resulting from unnecessary dependency and unproductiveness reached the billions of dollars.

**Defining Disability.** Coverage under the ADA is provided to individuals with disabilities who meet the three-part definitional criteria included in the act. Under the ADA an individual with a disability is defined as a person who: (a) has a physical or mental impairment that substantially limits one or more major life activities; or (b) has a record or history of such an impairment; or (c) is perceived or regarded as having such an impairment.<sup>6</sup>

The phrase "major life activities" is defined as the ability to carry out key activities or functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. The determination of "impairment" and the extent to which the impairment substantially limits a major life activity is made on an individual basis. The determination is not related to the presence or absence of a particular condition but rather to the impact that the condition or impairment has on the person and his or her ability to function in society. The extent to which an impairment "substantially limits" a major life activity is based on the conditions, manner, or duration under which the life activity can be performed by the individual as compared to others in society.

**Structure.** The ADA prohibits discrimination on the basis of disability in the areas of employment, public services provided by state and local governments, public services operated by private entities, transportation, certain commuter authorities such as AMTRAK, and telecommunications. The act is divided into three titles.

Title I Employment. Employment provisions apply to private employers, state and local governments, employment agencies, and labor unions. Title I prohibits discrimination

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<sup>6</sup> 29 CFR Section 1630.2(g): Disability. 76 FR 16980 Page 16980.

against "qualified individuals with disabilities" in all employment practices, including job application procedures, hiring, firing, advancement, compensation, training and other terms, conditions, and privileges of employment. Title I additionally covers recruitment, advertising, tenure, layoff, leave, fringe benefits, and all other employment-related activities.<sup>7</sup>

Title II - Public Accommodations by State and Local Governments. Title II covers programs, activities, and services of public entities and is divided into two subtitles. Subtitle A provides protections from discrimination on the basis of disability to people with disabilities in the services, programs, or activities of all state and local governments and extends the prohibition of discrimination on the basis of disability established by section 504 of the Rehabilitation Act of 1973, to all activities of state and local governments, including those that do not receive federal financial assistance. Subtitle B clarifies the requirements of section 504 for public transportation entities that receive federal financial assistance and extends coverage to all public entities that provide public transportation, whether or not they receive federal financial assistance.

The Title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."<sup>8</sup> The preamble discussion of the "integration regulation" describes "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible . . . ."<sup>9</sup>

Public entities are required under Title II to conduct a self-evaluation of current policies and practices and must ensure that individuals with disabilities are not excluded from services, programs, and activities because of building inaccessibility. The "program accessibility" standard does not require that public entities must make each of their existing facilities accessible. Covered entities may ensure access by modifying existing facilities, building or acquiring new facilities, relocating programs or services utilizing alternative sites or approaches to service delivery.

In order to receive protections under Title II, a "qualified" individual with a disability must meet the essential eligibility requirements for receiving or participation in services or programs furnished by a public entity with or without: (a) reasonable modifications to a public entity's rules, policies, or practices; (b) removal of architectural,

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<sup>7</sup> About the Americans with Disabilities Act of 1990 (ADA) Martin County Florida [www.martin.fl.us](http://www.martin.fl.us).

<sup>8</sup> 28 C.F.R. § 35.130(d) (the "integration mandate").

<sup>9</sup> 28 C.F.R. Pt. 35, App. A (2010).

communication, or transportation barriers; or (c) provision of auxiliary aids and services.<sup>10</sup>

Title III Public Accommodations by Private Business. A "public accommodation" refers to a privately operated entity that owns, leases, leases to, or operates a place of public accommodation. Title III prohibits discrimination on the basis of disability in all public accommodations operated by private businesses including, but not limited to hotels, restaurants, theaters, retail stores, museums, libraries, parks, private schools, and day care centers and other such entities. Places of public accommodation are required to remove barriers in existing facilities where it is "readily achievable," that is, where it can be "easily accomplished and able to be carried out without much difficulty or expense." Such readily achievable modifications include making structural changes to provide access around a few steps via a ramp or other means, lowering sinks in bathrooms, repositioning telephones, and other adjustments of this nature. Public accommodations may need to make alternative changes if the physical removal of a barrier is not possible or practicable such as furnishing direct assistance to people with disabilities to help them access items that are located on high shelves that are out of their reach, or assistance in finding items in stores.

### **The Olmstead Ruling: Key Provisions and Implications**

Since the ADA was signed into law in 1990 the act has resulted in positive changes in the lives and aspirations of people with disabilities across each of its four main policy goals: ensuring equality of opportunity, full participation, independent living, and economic self-sufficiency. Improvements in architectural design and construction, transportation, and communication accessibility brought about by the ADA have enable people with disabilities to experience greater independence and increasing levels of inclusion, employment, and community participation.

Among the most noteworthy outcomes of the ADA to date have been changes in the delivery of publicly financed services and supports that occurred as a result of the U.S. Supreme Court's decision in *Olmstead v. L.C.* in 1999. The case involved two women diagnosed with mental illness and developmental disabilities receiving voluntary treatment at a psychiatric unit in the state-funded Georgia Regional Hospital. In spite of the fact that their medical treatment had concluded and state mental health professionals had determined that each person was ready to move to a community-

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<sup>10</sup> *The Americans with Disabilities Act Title II Technical Assistance Manual. The Americans with Disabilities Act Title II Technical Assistance Manual Covering State and Local Government Programs and Services.*  
[www.ada.gov/taman2.html#II-1.3000](http://www.ada.gov/taman2.html#II-1.3000)

based setting, the women were not permitted to leave the facility. The two women brought suit against the state under the ADA for their release from the hospital. In June, 1999 the Supreme Court determined that the unjustified segregation of persons with disabilities constitutes discrimination and is in violation of Title II of the ADA. In this decision the court ruled that individuals with mental disabilities have the right to live in the community rather than in institutions and "that public entities must provide community-based services to persons with disabilities under three conditions when: (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity."<sup>11</sup>

**Integration Mandate and States' Obligations.** The Supreme Court noted that its finding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." And second, that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."<sup>12</sup> The court held that to comply with the ADA's integration mandate, public entities must make "reasonable accommodations" to their policies, procedures, or practices when necessary to avoid such discrimination. The obligation to make reasonable modifications may be excused only where the public entity demonstrates that the requested modifications would "fundamentally alter" its service system.<sup>13</sup> The Supreme Court's *Olmstead* ruling noted that if "a State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met." This means that, for a state to mount a fundamental alteration defense, it must have developed a comprehensive effectively

The *Olmstead* decision interprets public entities' obligations under Title II of the ADA and the parameters through which qualified individuals with disabilities are not subjected to discrimination, denied benefits, or excluded from participation in services, programs, or activities of a public entity.

<sup>11</sup> U.S. Department of Justice. Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* Accessed from [www.ada.gov/olmstead/q&a\\_olmstead.pdf](http://www.ada.gov/olmstead/q&a_olmstead.pdf) November 2012.

<sup>12</sup> *Olmstead v. L.C.*, 527 U.S. at 600-01 and 607.

<sup>13</sup> 28 C.F.R. § 35.130(b)(7).

working plan to end unnecessary segregation of individuals currently living in segregated programs and to furnish supports to individuals on waiting lists at a "reasonable pace" with the goal of integrating individuals with disabilities into mainstream society to the fullest extent possible.

Olmstead Plan. A state's Olmstead Plan provides the framework through which it intends to comply with its obligation to ensure people with disabilities have access to opportunities to live, work, and receive supports in integrated settings. The plan should provide an assessment of the state's current efforts to ensure individuals with disabilities receive services in the most integrated settings appropriate to their needs, identify policies and practices that may hinder the movement of people and services from segregated to integrated settings and the steps necessary to address waiting lists and other related policy goals. The plan must describe the state's commitments to expand integrated opportunities according to a reasonable timeframe and include measurable goals, specify the resources necessary to meet those goals, and identify the groups of people with disabilities who are to be covered by plan activities. Guidance from the DOJ Civil Rights Divisions suggests that plans should include specific commitments for each group of individuals with disabilities who are receiving segregated services and be able to demonstrate that progress toward effectively meeting its goals. It is important to note that states may use alternative strategies that accomplish the goals of an Olmstead plan. As of 2010, 26 states had written Olmstead plans while 18 states had published alternative strategies. The remaining seven states were reported to have neither an Olmstead plan nor an alternative response to Olmstead (DC, FL, ID, NM, RI, SD, and TN).<sup>14</sup> (See the PAS Personal Assistance Center's website for a listing of state Olmstead Plans at [www.pascenter.org/olmstead/olmsteadcases.php](http://www.pascenter.org/olmstead/olmsteadcases.php)).

States are obligated to comply with the ADA's integration mandate and may be found in violation of the act if the state funds, operates or administers its programs and services to individuals with disabilities in a way that results in their unjustified segregation or exclusion from society through its: (a) direct or indirect operation of facilities, programs or services; (b) financing of the delivery of services in private facilities; or (c) because it promotes or relies upon the segregation of individuals with disabilities in private facilities or programs through its planning, service system design, funding choices, or service implementation practices.<sup>15</sup>

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<sup>14</sup> Ng, T., Wong, A., and Harrington C. (April 2012). *Home and Community-Based Services: Introduction to Olmstead Lawsuits and Olmstead Plans*. National Center for Personal Assistance Services University of California at San Francisco.

<sup>15</sup> 28 C.F.R. § 35.130(b)(1).



The integration mandate obligates states to:

- Furnish supports and services to individuals with disabilities in integrated settings that offer choices and opportunities to live, work, and participate in community activities along with individuals without disabilities at times and frequencies of the person's choosing.
- Afford choice in their activities of daily life and the opportunity to interact with non-disabled persons to the fullest extent possible.
- Provide individuals with an assessment of their needs and the supports necessary for them to succeed in integrated settings by professionals who are knowledgeable about the variety of services available in the community.
- Enable people with disabilities to make informed choices about the decision to reside in the most integrated settings by furnishing information about the benefits of integrated settings, facilitating on-site visits to community programs and providing opportunities to meet with other individuals with disabilities who are living, working and receiving supports in integrated community settings, with their families, and in other arrangements.
- Protect people with disabilities from the risk of institutionalization resulting from service or support reductions or reconfigurations as a result of state funding reductions through the provision of support alternatives that do not result in institutionalization.

Integration Mandate Prevails. It is important to note that a state's obligations to comply with the ADA integration mandate are independent and in addition to and separate from any regulations or requirements of Medicaid programs under Title XIX of the Social Security Act. A state could, for example, decide to address its wait list for developmental disabilities services by increasing placements in Medicaid funded institutional ICF/ID facilities and expanding the use of segregated institutional programs for all people with autism. This approach would not necessarily run afoul of Medicaid financing or operational guidelines but would violate the ADA's integration mandate by unnecessarily segregating people through the lack of more integrated support options and by providing certain services only in segregated settings. Requiring the state to change its policy would not be considered a "fundamental alteration." Similarly, under Section 1915(c) of the Social Security Act states are allowed to place a cap on the number of eligible individuals with disabilities they will serve

through their home and community-based Medicaid waiver programs. While consistent with Medicaid regulations, the presence of such a cap does not remove the obligation of the state under the ADA to serve individuals with disabilities in the most integrated settings appropriate to their needs. To comply in this example, the state may need to submit a waiver amendment to increase the numbers served or take additional steps to reduce its reliance on segregated support alternatives. As above, it is doubtful that such an action would be considered a fundamental alteration of the state's program.

## Conditions Under Which Olmstead Applies

The provisions of the ADA under the Olmstead ruling apply to people of all ages with all types of disabilities (see definition of eligible disabilities above<sup>16</sup>). Under Title II of the ADA, an individual with a disability is "qualified" if he or she meets the eligibility requirements for receiving services or participating in the public program or activity. On an operational level, the Olmstead decision has been interpreted by DOJ to apply to people with disabilities who receive services from segregated institutions or settings, as well as those who are at risk of institutionalization as a result of the lack of the availability or accessibility of publicly funded services and supports in the community. The definition of a segregated setting encompasses: "(1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities."<sup>17</sup>

Given the broad interpretation of the scope of the Olmstead ruling it is difficult to identify the total number of individuals that are covered under the act's provisions. In 2001, the Government Accounting Office noted that the implementation of the Olmstead ruling was taking place in the context of expanding numbers of aging baby boomers and individuals with disabilities, and that the full extent of the population covered by the ruling was unclear.<sup>18</sup> The estimation of the total numbers of individuals

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<sup>16</sup> A person with disability under the ADA is defined as a person: (a) with a physical or mental impairment that substantially limits one or more of an individual's major life activities, (b) with a record of such an impairment, or (c) who is regarded as having such an impairment. 42 U.S.C. §12102(2).

<sup>17</sup> U.S. Department of Justice. Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* Accessed from [www.ada.gov/olmstead/q&a\\_olmstead.pdf](http://www.ada.gov/olmstead/q&a_olmstead.pdf), November 2012.

<sup>18</sup> General Accounting Office Testimony Before the Special Committee on Aging, U.S. Senate. (September 24, 2001). *Long Term Care: Implications of the Supreme Court's Olmstead Decision are Still Unfolding* by Kathryn Allen.

to whom the act applies remains challenging in 2012. Existing data on persons with disabilities receiving public supports in institutional and community programs nationwide suggests that the act could be expected to cover approximately 37,853,991 individuals in 2010. This number is based on the following:

- Approximately 1,499,279 people with disabilities resided in institutional settings in 2010. This estimate includes 1,385,251 in nursing facilities,<sup>19</sup> 31,101 people with developmental disabilities in state institutions, 25,927 individuals with developmental disabilities living in publicly funded private residential facilities with greater than 15 beds,<sup>20</sup> and 57,000 people in state mental health facilities.<sup>21</sup> Researchers have long used 15 beds as the size or capacity criteria separating institutional from community-based settings. While this benchmark may facilitate the gathering and reporting of data across states, the figure is arbitrary and makes little sense when placed against the Olmstead integration mandate requiring public entities to support individuals with disabilities in the most integrated settings appropriate to their needs. Including the numbers of persons with disabilities residing in settings of between 4 and 15 beds would significantly increase the total. Furthermore, it is important to note that the provisions of the Olmstead ruling also apply to people living in community settings and with families who might be at risk of institutionalization.
- Approximately 36,354,712 individuals with disabilities ages 5 years and over lived in the community in 2010. Based on a total U.S. population of 304,287,836 this yields a prevalence rate of 11.9 percent. The range among states was between California with 3,640,092 individuals with disabilities and Wyoming, with 65,570 individuals with disabilities. The state with the highest prevalence rate was West Virginia at 18.9 percent; Utah had the lowest prevalence rate, 8.5 percent.<sup>22</sup>

## Enforcement of the Olmstead Integration Mandate

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<sup>19</sup> C. Harrington, H. Carrillo, M. Dowdell, P. Tang, and B. Blank. Table 4, *Nursing, Facilities, Staffing, Residents, and Facility Deficiencies, 2005 Through 2010*, Department of Social and Behavioral Sciences, University of California, San Francisco.

<sup>20</sup> Larson, S.A., Ryan, A., Salmi, P., Smith, D., and Wuorio, A. (2012). *Residential Services for Persons with Developmental Disabilities: Status and trends through 2010*. Minneapolis: University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.

<sup>21</sup> Ibid. General Accounting Office Testimony

<sup>22</sup> Institute on Disability. (2011). American Community Survey. In 2011 Annual Disability Statistics Compendium: Disability Statistics and Demographics Rehabilitation Research and Training Center. University of New Hampshire.

Enforcement of the Olmstead integration mandate is a central priority of the Obama Administration and a focus of the Year of Community Living initiative launched in 2009. Department of Justice officials note that the Olmstead ruling encompasses more than requiring that people with disabilities move out of institutions and that enforcement efforts have been organized around three broad goals designed to ensure that people with disabilities have the services and supports that they need to live and thrive in the community. Focus is on ensuring people with disabilities: (a) have opportunities to live life like people without disabilities; (b) have opportunities for integration, independence, recovery, choice and self-determination in all aspects of life – in the settings in which they live, the activities that occupy their time during the day, their work, and in their access to the community; and (c) receive quality services that meet their individual needs.<sup>23</sup>

In carrying out its responsibilities to ensure compliance with the ADA and the Olmstead ruling, DOJ utilizes an array of administrative and legal tools, including: (a) direct investigations of state policies and practices; (b) the preparation and issuance of Findings Letters reporting on the results and conclusions of their investigations, leading to; (c) Settlement Agreements with states on an acceptable course of action to bring illegal policies and practices into compliance with the ABA; and (d) litigation for system reform. DOJ additionally offers technical assistance and guidance to states on Olmstead requirements and expectations, and provides information and materials for interested parties on its website, [www.ada.gov/olmstead](http://www.ada.gov/olmstead).

Samuel Bagenstos, Principal Deputy Assistant Attorney General of the Department of Justice Civil Rights Division, noted in remarks to the University of Cincinnati in 2010, that the U.S. Department of Justice had brought, intervened in, or participated as an amicus or interested party in Olmstead litigation in an increasingly large number of states nationwide. Since that time, actions brought by the Civil Rights Division has expanded to over 40 matters in 25 states (see [www.ada.gov/olmstead/index.htm](http://www.ada.gov/olmstead/index.htm))

The initial focus of Olmstead enforcement was on enabling people with disabilities who were unnecessarily segregated in institutions to receive needed services and supports in the most integrated community settings appropriate to their needs. In recent years, however, enforcement patterns have expanded to include the extent to which the availability, quality and responsiveness of existing publicly funded community-based service delivery systems protected individuals with disabilities from unnecessary segregation. This trend can be seen in the language and focus of the comprehensive

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<sup>23</sup> Thomas E. Perez Assistant Attorney General Civil Rights Division Department Of Justice before the Senate Committee on Health, Education, Labor and Pensions, U.S. Senate titled "Olmstead Enforcement Update: Using The Ada To Promote Community Integration" Presented on June 21, 2012.

settlement agreements that the DOJ entered into with states during the past several years.

**Georgia.** DOJ settled with the state of Georgia, for example, in October 2010 to resolve the complaint that Georgians with developmental disabilities and individuals with mental illness were being unnecessarily and unconstitutionally institutionalized and subjected to conditions that would harm their lives, health, and safety in violation of the ADA and the U.S. Constitution. The agreement requires Georgia officials to change policies and to take a number of very specific operational steps to ensure people with developmental disabilities and those with mental illness receive appropriate services in the most integrated settings appropriate to their needs. Regarding people with developmental disabilities, Georgia agreed to take several significant actions including:

- End all admissions to state-operated institutions by July 1, 2011, and transition all individuals to the most integrated setting appropriate to their needs by July 1, 2015.
- Expand its home and community-based waiver program to serve at least 1,100 individuals with DD in the community to: (a) furnish supports to people in their own or their family's homes, (b) provide family supports to 2,350 families, (c) create 6 mobile crisis teams to all communities, and (d) establish 12 crisis respite homes.<sup>24</sup>

The state agreed to enact similar reforms for people with mental illness agreeing to serve 9,000 individuals with serious and persistent mental illness in the community who are "currently served in State Hospitals; frequently readmitted to State Hospitals; frequently seen in emergency rooms; chronically homeless and/or being released from jails or prisons." Furthermore, the state agreed to:

- Establish a range of community services and supports including: 22 Assertive Community Treatment teams; 8 Community Support teams to provide services in individuals' own homes; 14 Intensive Case Management teams; 45 Case Management service providers; 6 Crisis Services Centers; 3 additional Crisis Stabilization Programs; 35 community-based psychiatric beds; and an array of mobile crisis teams, crisis apartments, supported housing, supported employment, and peer support services.

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<sup>24</sup> U.S. v. *State of Georgia* Civil No. 1:10-CV-249-CAP October 2010 Settlement Agreement fact sheet.

- The agreement also provides for a state-wide quality management system for community services.<sup>25</sup>

**Virginia.** The emphasis on states' the establishment of a community-based service delivery infrastructure in DOJ's enforcement activities was underscored in a landmark settlement with the commonwealth of Virginia aimed at ending the unnecessarily institutionalization of people with intellectual and developmental disabilities throughout its service delivery system. The DOJ's broad based approach to the enforcement of the Olmstead integration mandate is outlined in the letter from Thomas Perez, Assistant Attorney General of the DOJ Office of Civil Rights to the governor of Virginia reporting the department's findings of the Investigation of the Commonwealth of Virginia's Compliance with the American's with Disabilities Act and of Central Virginia Training Center dated February 10, 2011. In this correspondence, and in the subsequent settlement with the state,<sup>26</sup> DOJ cited a number of "systemic failures" in the Commonwealth's service delivery system "causing unnecessarily institutionalization" throughout the system including:

- The failure to develop a sufficient number of community-based institutional alternatives, especially for people with complex needs.
- The failure to use available resources to expand community services and re-align existing resources to prioritize investments in non-institutional settings.
- The presence of a flawed process for discharge planning that identified discharge barriers, individual's needs, and services necessary to meet those needs.
- The failure to develop sufficient numbers of services in the community to meet waiting lists and address the needs of persons at immediate risk of institutionalization.
- The failure to develop the crisis response and respite capacity necessary to prevent people with disabilities in crisis from being institutionalized due to the lack of alternatives.<sup>27</sup>

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<sup>25</sup> Ibid. *U.S. v. State of Georgia* above.

<sup>26</sup> *U.S. v. Commonwealth of Virginia* - 3:12CV059 (E.D. VA 2012).

<sup>27</sup> Thomas E. Perez (2011). Letter to Governor Robert McDonnell Re: Investigation of the Commonwealth of Virginia's Compliance with the American's with Disabilities Act and of Central Virginia Training Center (see [www.ada.gov/olmstead/olmstead\\_cases\\_list2.htm#va](http://www.ada.gov/olmstead/olmstead_cases_list2.htm#va)).

DOJ entered into a comprehensive settlement agreement with the commonwealth of Virginia designed to make sweeping changes in the state's service delivery system for persons with disabilities. The state agreed over the next 10 years to expand the 1915(c) Medicaid waiver program in order to: (a) move 800 individuals with I/DD from state training centers to community programs, (b) furnish supports to 3,000 adults and youth with intellectual disabilities who on the state's "urgent" waitlist and/or are being served in private institutions, and (c) provide program supports to 450 adults and youth with developmental disabilities currently being served in private institutions. Additional provisions of the settlement call for the development of comprehensive and coordinated strategies to ensure families of children and adults with disabilities have access to resources, supports and services; the development of mobile crisis teams, community-based crisis stabilization and respite services, and a 24 hour 7 day per week crisis hotline. Under the settlement, the state also agreed to expand: the availability of integrated housing supporting people in their own homes, in small settings of four or fewer individuals with disabilities, or with their families; access to integrated employment and day activity opportunities under the 1915(c) Medicaid waiver and institute an employment first policy; improve access to case management and provide enhanced case management for people with complex needs, who are experiencing crisis living in congregate settings and are being discharged for state training centers.<sup>28</sup>

**Other States.** As noted above, the obligations of states to furnish services to individuals with disabilities in the most integrated settings applies to individuals with disabilities receiving all types of public support not just those living in segregated institutional settings. DOJ's Olmstead enforcement activities have extended beyond publicly operated institutional facilities to include people receiving public supports that result in their inappropriate and illegal segregation in privately owned and operated nursing homes, day programs, and other facility based alternatives. A summary of Olmstead litigation activities in the 12 U.S. Circuit Courts of Appeals is available from the Department of Justice' website at [www.ada.gov/olmstead/olmstead\\_enforcement.htm](http://www.ada.gov/olmstead/olmstead_enforcement.htm).

**State Operated Facilities.** The DOJ Civil Rights Division has issued Findings Letters and involved in Settlement Agreements regarding people with disabilities who are living in, or at-risk of entering state-operated facilities in several states including:

- *U.S. v. State of Georgia* expanding community services and supports for more than 1,000 people in state I/DD facilities and on waitlist for services (see above).

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<sup>28</sup> See [www.justice.gov/crt/about/spl/virginia-ada.php](http://www.justice.gov/crt/about/spl/virginia-ada.php) for the settlement agreement, fact sheet, complaint, and investigative findings.

- *U.S. v. Commonwealth of Virginia* resulting in the broad expansion of community support options for more than 4,200 people with I/DD disabilities in state and private facilities and on the state's waitlists (see above).
- *DOJ's Findings Letter State of Mississippi* identifying violations on behalf of adults and children in public and private DD facilities and concluding that the state is violating the ADA's integration mandate in its provision of services to adults and children with developmental disabilities and mental illness by unnecessarily institutionalizing persons with mental illness or DD in public and private facilities and failing to ensure that they, as well as people on wait lists for services, are offered a meaningful opportunity to live in integrated community settings consistent with their needs.
- *U.S. v. State of New Hampshire (Lynn v. Lynch)* addressing the needs of people with mental illness who reside in or are at risk of entering the state psychiatric hospital and state-operated nursing facility for people with mental illness.

Private Facilities. The Civil Rights Division has intervened to prevent the unnecessary segregation of people with disabilities in private facilities receiving public support.

- *Nursing Homes and Private Facilities*
  - i. Texas - Intervention in *Steward v. Perry*, DOJ was granted a request to intervene in a pending lawsuit against the state alleging violations of Title II of the ADA and Section 504 of the Rehabilitation Act for unnecessarily segregating individuals with developmental disabilities in nursing facilities. The intervention addressed the needs of thousands of people with I/DD in and at-risk of entering private nursing homes in the state with the Arc of Texas as an organizational plaintiff.
  - ii. Virginia - Investigation regarding children with DD in nursing homes, relief was included in the VA agreement (see above).
  - iii. Florida – Findings Letter issued in September 2012 concluded the state of Florida was violating the ADA's integration mandate in its provision of services and supports to children with medically complex and medically fragile conditions. DOJ found that the state of Florida plans, structures, and administers a system of care that has led to the unnecessary institutionalization of children in nursing facilities and places children



currently residing in the community at risk of unnecessary institutionalization.

- iv. New York – DOJ intervened in *DAI v Cuomo* regarding people with mental illness living in adult homes in New York City who were seeking integrated supported housing and community supports.
- *Private Intermediate Care Facilities*. Statement of Interest was issued in private litigation.
  - *Day Programs and Services*. Civil Rights Division activities have made it clear that the provisions of the ADA and the Olmstead ruling are not limited to the settings where people live but also apply to the supports and services that people with disabilities receive during the day.
    - i. Oregon - *Lane v. Kitzhaber* Statement of Interest and, Findings Letter concluding that the state of Oregon violates the ADA's integration mandate in its provision of employment and vocational services because it plans, structures, and administers employment and vocational services for individuals with I/DD primarily in segregated sheltered workshops rather than in integrated community employment settings. This causes the unnecessary segregation of individuals in sheltered workshops that are capable of, and not opposed to, receiving employment services in the community. DOJ recommended that the state implement remedial measures, including the development of sufficient supported employment services to enable those individuals unnecessarily segregated, or at risk of unnecessary segregation, in sheltered workshops to receive services in individual integrated employment settings in the community.
    - ii. Virginia - Settlement of *U.S. v. Commonwealth of Virginia* and Olmstead settlements in Delaware, North Carolina, and Georgia resulted in expansions of supported employment and integrated day activities in each of those states.
  - *Community Services*.
    - i. Delaware – Settlement of *U.S. v. State of Delaware* resulting in the expansion of community services for more than 3,000 people with mental illness residing in or at risk of entering state psychiatric hospitals and private Institutes for Mental Disease (IMD) facilities. The settlement also

expanded access to ACT services, crisis services, and supported employment, intensive case management, peer and family supports. The settlement expanded the availability of integrated scattered site housing, rental vouchers and subsidies and assurance that housing complexes would have no more than 20 percent people with disabilities in residence.

- *At Risk Cases.* In a significant number of instances the DOJ Statements of Interest filed in support of private plaintiffs have included reference to practices and policies that result in the unnecessary segregation of individuals with disabilities as a result of:
  - i. State cuts to critical services without individualized assessments of impact or an exceptions process for those with special conditions or treatment needs.
  - ii. Policies requiring people with disabilities to enter an institution to move to top of a waiting list for community services rather than being furnished with services in an integrated setting in the first instance.
  - iii. Provisions limiting the delivery of needed services to persons living in an institution but not in the community
  - iv. State budgetary reductions to critical community mental health services supporting private litigation in California to prevent cuts to services for people with mental illness who had been determined to be at risk of out-of-home placements without those services.
  - v. The lack of intensive, community-based and "wrap-around" services for children with mental/behavioral health conditions.

## Conclusion

The Olmstead ruling in 1999 established that the unnecessary segregation of people with disabilities in institutions is a form of discrimination under Title II of the Americans with Disabilities Act of 1990. In this decision, the Supreme Court reviewed the definition of disability under the ADA and clarified the relationship between the presence of a particular physical or mental condition and the extent to which such an "impairment" substantially limits major life activities. The Olmstead ruling established the role and responsibilities of states and public entities with respect to their obligations under Title II of the ADA to ensure that eligible individuals with disabilities receive public services within "the most integrated setting" appropriate to their needs. The Olmstead integration mandate provides a framework through which qualified individuals with disabilities are not subjected to discrimination, denied benefits or excluded from participation in society through the delivery, provision or funding of services, programs, or activities by a public entity.

The provisions of the ADA as interpreted by the Olmstead ruling are comprehensive and apply to all services and supports furnished or funded by or through public entities. In the distant past, publicly financed services were provided in facility-based programs, segregated away from society. Since that time service delivery methods, designs and strategies have changed significantly in response to individual and family advocacy, progressive legislation at the federal and state levels, improved instructional and support methodologies and a growing understanding of the deleterious impact that segregation and exclusion from society has on the lives of individuals with disabilities. Although service delivery approaches have changed, reflecting a greater emphasis on integrated community-based services, federal funding mechanisms and states' systems of support for people with disabilities have continued to be anchored in traditional service models that result in unnecessary segregation of individuals with disabilities and their exclusion from society. The passage of the ADA and the Olmstead ruling recognizes in law the obsolescence of traditional non-integrated approaches and provides a broad system change framework for public entities to follow to improve service delivery and the lives of people receiving supports and carry out Congress' "comprehensive national mandate for the elimination of discrimination against individuals with disabilities."<sup>29</sup>

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<sup>29</sup> 42 U.S.C. § 12101(b)(1).

## Annotated References

1. About the Americans with Disabilities Act of 1990 (ADA) Martin County Florida  
[www.martin.fl.us/portal/page?\\_pageid=352,830377&\\_dad=portal&\\_schema=PORTAL](http://www.martin.fl.us/portal/page?_pageid=352,830377&_dad=portal&_schema=PORTAL)
2. DOJ website on Olmstead  
[www.ada.gov/olmstead/index.htm](http://www.ada.gov/olmstead/index.htm)
  - DOJ Website on ADA enforcement and Technical Assistance materials:  
[www.ada.gov/publicat.htm](http://www.ada.gov/publicat.htm)
  - DOJ website on Litigation and Enforcement  
[www.ada.gov/olmstead/olmstead\\_enforcement.htm](http://www.ada.gov/olmstead/olmstead_enforcement.htm).
3. Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* U.S. Department of Justice Civil Rights Division.  
[www.ada.gov/olmstead/q&a\\_olmstead.pdf](http://www.ada.gov/olmstead/q&a_olmstead.pdf)
4. *Olmstead: Reclaiming Institutionalized Lives* (August 2003). National Council on Disability. Accessed from the NCD website November 2012.  
[www.ncd.gov/publications/2003/Aug192003](http://www.ncd.gov/publications/2003/Aug192003).

In this report, the National Council on Disability (NCD) assesses the nation's response to the U.S. Supreme Court's ruling in *Olmstead v. L.C.*, 527 U.S. 581 (1999) that the unjustified institutionalization of people with disabilities is a form of discrimination. NCD examines the federal government's implementation efforts and the strategies states and key stakeholders are using to (1) develop consensus on a coordinated action plan, (2) identify and commit the necessary resources for community-based service options, and (3) sustain collaborative action toward creating real choice for people with disabilities living in institutions.

5. Ng, T., Wong, A., and Harrington C. (April 2012). *Home and Community-Based Services: Introduction to Olmstead Lawsuits and Olmstead Plans*. National Center for Personal Assistance Services University of California at San Francisco. For a state by state summary of Olmstead lawsuits see  
[www.pascenter.org/olmstead/olmsteadcases.php](http://www.pascenter.org/olmstead/olmsteadcases.php).

6. U.S. Equal Employment Opportunity Commission Fact Sheet on the EEOC's Final Regulations Implementing the ADAAA.  
[www.eeoc.gov/laws/regulations/adaaa\\_fact\\_sheet.cfm](http://www.eeoc.gov/laws/regulations/adaaa_fact_sheet.cfm)
  
7. The Americans with Disabilities Act Title II Technical Assistance Manual. The Americans with Disabilities Act Title II Technical Assistance Manual Covering State and Local Government Programs and Services.  
[www.ada.gov/taman2.html#II-1.3000](http://www.ada.gov/taman2.html#II-1.3000)

This technical assistance manual addresses the requirements of Title II of the Americans with Disabilities Act, which applies to the operations of state and local governments. This manual presents the ADA's requirements for state and local governments in an easily accessible format providing a focused, systematic description of the ADA's requirements.

at a minimum, include the following:

1.2.1 Students in grades 1-8 must receive instruction in English Language Arts or its equivalent, mathematics, social studies and science each year as defined in the Delaware Content Standards.

1.2.2 Students in grades 1-8 must pass 50% of their instructional program each year (excluding physical education) to be promoted to the next grade level. One of the subject areas that must be passed is English Language Arts or its equivalent. English Language Arts or its equivalent includes English as a Second Language (ESL), and bilingual classes that are designed to develop the English language proficiency of students who have been identified as LEP. Classes in English Language Arts, mathematics, science and social studies include those which employ alternative instructional methodologies designed to meet the needs of LEP students in the content areas.]

It was determined that no written materials or suggestions had been received from any individual or the public.

**FINDINGS OF FACT:**

The Department finds that the proposed changes, as set forth in the attached copy should be made in the best interest of the general public of the State of Delaware.

THEREFORE, IT IS ORDERED that the proposed regulations of the Child Care Manual and the elimination of the First Step Manual are adopted and shall become effective ten days after publication of the final regulation in the Delaware Register.

November 30, 1998  
GREGG C. SYLVESTER, MD  
SECRETARY

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**DEPARTMENT OF HEALTH AND  
SOCIAL SERVICES**

**DIVISION OF SOCIAL SERVICES**  
Statutory Authority: 31 Delaware Code,  
Section 512 (31 Del.C. 512)

IN THE MATTER OF:

REVISION OF THE CHILD CARE  
AND THE FIRST STEP REGULATIONS  
NATURE OF THE PROCEEDINGS:

The Delaware Health and Social Services, Division of Social Services, initiated proceedings to change policy governing the Child Care and First Step programs to the Division of Social Services' Manual Sections 11000 and 12000, pursuant to the Administrative Procedures Act. The policy changes arose from the Personal Responsibility and Work Opportunity Act, the new Child Care and Development Block Grant and *A Better Chance* provisions.

On September 9, 1998, the DHSS published in the Delaware Register of Regulations (pages 466-485) its notice of proposed regulation changes, pursuant to 29 Delaware Code Section 10115. It requested that written materials and suggestions from the public concerning the proposed be delivered by October 31, 1998, at which time the Department would review information, factual evidence and public comment to the said proposed changes to the regulations.

\* Please note that no changes were made to the regulation as originally proposed and published in the October 1998 issue of the Register at page 466 (2:4 Del. R. 466). Therefore, the final regulation is not being republished. Please refer to the October 1998 issue of the Register or contact the Department of Health & Social Services

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**DIVISION OF SOCIAL SERVICES**  
Statutory Authority: 31 Delaware Code,  
Section 505 (31 Del.C. 505)

Medicaid / Medical Assistance Program

IN THE MATTER OF:

REVISION OF THE REGULATIONS  
OF THE MEDICAID/MEDICAL  
ASSISTANCE PROGRAM

NATURE OF THE PROCEEDINGS:

The Delaware Department of Health and Social Services ("Department") initiated proceedings to update the Medicaid definition of Medical Necessity. 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 November 1998 Delaware Register of Regulations, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by December 1, 1998, at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

A recent publication of Federally mandated Medicaid policy required that the definition of medical necessity be revised before being made final. Therefore, following is the revised definition as it will appear in Delaware Medicaid policy.

#### FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the November 1998 Register of Regulations should be adopted as amended.

THEREFORE, IT IS ORDERED, that the proposed regulations of the Medicaid/Medical Assistance Program are adopted and shall be final effective January 10, 1999.

December 9, 1998  
Gregg C. Sylvester, M.D.  
Secretary

#### MEDICAL NECESSITY DEFINITION

MEDICAL NECESSITY is defined as:

the essential need for medical care or services (all covered State Medicaid Plan services, subject to age and eligibility restrictions and/or EPSDT requirements) which, when prescribed by the beneficiary's primary physician care manager and delivered by or through authorized and qualified providers, will:

- be directly related to the diagnosed medical condition or the effects of the condition of the beneficiary (the physical or mental functional deficits that characterize the beneficiary's condition), and be provided to the beneficiary only;
- be appropriate and effective to the comprehensive profile (e.g. needs, aptitudes, abilities, and environment) of the beneficiary and the beneficiary's family;
- be primarily directed to treat the diagnosed medical condition or the effects of the condition of the beneficiary, in all settings for normal activities of daily living, but will not be solely for the convenience of the beneficiary, the beneficiary's family, or the beneficiary's provider. ~~(this means that services which are primarily used for educational, vocational, social, recreational, or other non-medical purposes are not covered under the Medicaid program) and not include medications, devices, or services that are used primarily to provide lifestyle enhancements;~~

~~even if conditions are medically based (for example, Viagra, Weight Watchers, etc.);~~

- be timely, considering the nature and current state of the beneficiary's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;
- be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of program funds;
- be the most appropriate care or service that can be safely and effectively provided to the beneficiary, and will not duplicate other services provided to the beneficiary;
- be sufficient in amount, scope and duration to reasonably achieve its purpose;
- be recognized as either the treatment of choice (i.e. prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of other care and services that are commonly provided;
- be rendered in response to a life threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay;

and will be reasonably determined to:

- diagnose, cure, correct or ameliorate defects and physical and mental illnesses and diagnosed conditions or the effects of such conditions; or
- prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay; or
- effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program; or
- restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury or condition; or
- provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat, or support a diagnosed condition or the effects of the condition,

in order that the beneficiary might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all natural family, community, and facility environments and activities.

been decided in a due process hearing involving the same parties—

- (i) The due process hearing decision is binding on that issue; and
  - (ii) The SEA must inform the complainant to that effect.
- (3) A complaint alleging a public agency's failure to implement a due process hearing decision must be resolved by the SEA.

Approved by the Office of Management and Budget under control numbers 1820-0030 and 1820-0600.

(Authority: 20 U.S.C. 1221e-3)

### § 300.153 Filing a complaint.

(a) An organization or individual may file a signed written complaint under the procedures described in §§ 300.151 through 300.152.

(b) The complaint must include—

(1) A statement that a public agency has violated a requirement of Part B of the Act or of this part;

(2) The facts on which the statement is based;

(3) The signature and contact information for the complainant; and

(4) If alleging violations with respect to a specific child—

(i) The name and address of the residence of the child;

(ii) The name of the school the child is attending;

(iii) In the case of a homeless child or youth (within the meaning of section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), available contact information for the child, and the name of the school the child is attending;

(iv) A description of the nature of the problem of the child, including facts relating to the problem; and

(v) A proposed resolution of the problem to the extent known and available to the party at the time the complaint is filed.

(c) The complaint must allege a violation that occurred not more than one year prior to the date that the complaint is received in accordance with § 300.151.

(d) The party filing the complaint must forward a copy of the complaint to the LEA or public agency serving the child at the same time the party files the complaint with the SEA.

(Approved by the Office of Management and Budget under control numbers 1820-0030 and 1820-0600)

(Authority: 20 U.S.C. 1221e-3)

### Methods of Ensuring Services

#### § 300.154 Methods of ensuring services.

(a) *Establishing responsibility for services.* The Chief Executive Officer of a State or designee of that officer must

ensure that an interagency agreement or other mechanism for interagency coordination is in effect between each noneducational public agency described in paragraph (b) of this section and the SEA, in order to ensure that all services described in paragraph (b)(1) of this section that are needed to ensure FAPE are provided, including the provision of these services during the pendency of any dispute under paragraph (a)(3) of this section. The agreement or mechanism must include the following:

(1) An identification of, or a method for defining, the financial responsibility of each agency for providing services described in paragraph (b)(1) of this section to ensure FAPE to children with disabilities. The financial responsibility of each noneducational public agency described in paragraph (b) of this section, including the State Medicaid agency and other public insurers of children with disabilities, must precede the financial responsibility of the LEA (or the State agency responsible for developing the child's IEP).

(2) The conditions, terms, and procedures under which an LEA must be reimbursed by other agencies.

(3) Procedures for resolving interagency disputes (including procedures under which LEAs may initiate proceedings) under the agreement or other mechanism to secure reimbursement from other agencies or otherwise implement the provisions of the agreement or mechanism.

(4) Policies and procedures for agencies to determine and identify the interagency coordination responsibilities of each agency to promote the coordination and timely and appropriate delivery of services described in paragraph (b)(1) of this section.

(b) *Obligation of noneducational public agencies.* (1)(i) If any public agency other than an educational agency is otherwise obligated under Federal or State law, or assigned responsibility under State policy or pursuant to paragraph (a) of this section, to provide or pay for any services that are also considered special education or related services (such as, but not limited to, services described in § 300.5 relating to assistive technology devices, § 300.6 relating to assistive technology services, § 300.34 relating to related services, § 300.41 relating to supplementary aids and services, and § 300.42 relating to transition services) that are necessary for ensuring FAPE to children with disabilities within the State, the public agency must fulfill that obligation or responsibility, either directly or through contract or other arrangement pursuant to paragraph (a) of this section or an

agreement pursuant to paragraph (c) of this section.

(ii) A noneducational public agency described in paragraph (b)(1)(i) of this section may not disqualify an eligible service for Medicaid reimbursement because that service is provided in a school context.

(2) If a public agency other than an educational agency fails to provide or pay for the special education and related services described in paragraph (b)(1) of this section, the LEA (or State agency responsible for developing the child's IEP) must provide or pay for these services to the child in a timely manner. The LEA or State agency is authorized to claim reimbursement for the services from the noneducational public agency that failed to provide or pay for these services and that agency must reimburse the LEA or State agency in accordance with the terms of the interagency agreement or other mechanism described in paragraph (a) of this section.

(c) *Special rule.* The requirements of paragraph (a) of this section may be met through—

(1) State statute or regulation;

(2) Signed agreements between respective agency officials that clearly identify the responsibilities of each agency relating to the provision of services; or

(3) Other appropriate written methods as determined by the Chief Executive Officer of the State or designee of that officer and approved by the Secretary.

(d) *Children with disabilities who are covered by public benefits or insurance.*

(1) A public agency may use the Medicaid or other public benefits or insurance programs in which a child participates to provide or pay for services required under this part, as permitted under the public benefits or insurance program, except as provided in paragraph (d)(2) of this section.

(2) With regard to services required to provide FAPE to an eligible child under this part, the public agency—

(i) May not require parents to sign up for or enroll in public benefits or insurance programs in order for their child to receive FAPE under Part B of the Act;

(ii) May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but pursuant to paragraph (g)(2) of this section, may pay the cost that the parents otherwise would be required to pay;

(iii) May not use a child's benefits under a public benefits or insurance program if that use would—



- (A) Decrease available lifetime coverage or any other insured benefit;
- (B) Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school;
- (C) Increase premiums or lead to the discontinuation of benefits or insurance; or

(D) Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures; and

(iv)(A) Must obtain parental consent, consistent with § 300.9, each time that access to public benefits or insurance is sought; and

(B) Notify parents that the parents' refusal to allow access to their public benefits or insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.

(e) *Children with disabilities who are covered by private insurance.* (1) With regard to services required to provide FAPE to an eligible child under this part, a public agency may access the parents' private insurance proceeds only if the parents provide consent consistent with § 300.9.

(2) Each time the public agency proposes to access the parents' private insurance proceeds, the agency must—

(i) Obtain parental consent in accordance with paragraph (e)(1) of this section; and

(ii) Inform the parents that their refusal to permit the public agency to access their private insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.

(f) *Use of Part B funds.* (1) If a public agency is unable to obtain parental consent to use the parents' private insurance, or public benefits or insurance when the parents would incur a cost for a specified service required under this part, to ensure FAPE the public agency may use its Part B funds to pay for the service.

(2) To avoid financial cost to parents who otherwise would consent to use private insurance, or public benefits or insurance if the parents would incur a cost, the public agency may use its Part B funds to pay the cost that the parents otherwise would have to pay to use the parents' benefits or insurance (e.g., the deductible or co-pay amounts).

(g) *Proceeds from public benefits or insurance or private insurance.* (1) Proceeds from public benefits or insurance or private insurance will not

be treated as program income for purposes of 34 CFR 80.25.

(2) If a public agency spends reimbursements from Federal funds (e.g., Medicaid) for services under this part, those funds will not be considered "State or local" funds for purposes of the maintenance of effort provisions in §§ 300.163 and 300.203.

(h) *Construction.* Nothing in this part should be construed to alter the requirements imposed on a State Medicaid agency, or any other agency administering a public benefits or insurance program by Federal statute, regulations or policy under title XIX, or title XXI of the Social Security Act, 42 U.S.C. 1396 through 1396v and 42 U.S.C. 1397a through 1397j, or any other public benefits or insurance program.

(Approved by the Office of Management and Budget under control number 1820-0030)

(Authority: 20 U.S.C. 1412(a)(12) and (e))

#### Additional Eligibility Requirements

##### § 300.155 Hearings relating to LEA eligibility.

The SEA must not make any final determination that an LEA is not eligible for assistance under Part B of the Act without first giving the LEA reasonable notice and an opportunity for a hearing under 34 CFR 76.401(d).

(Approved by the Office of Management and Budget under control number 1820-0030)

(Authority: 20 U.S.C. 1412(a)(13))

##### § 300.156 Personnel qualifications.

(a) *General.* The SEA must establish and maintain qualifications to ensure that personnel necessary to carry out the purposes of this part are appropriately and adequately prepared and trained, including that those personnel have the content knowledge and skills to serve children with disabilities.

(b) *Related services personnel and paraprofessionals.* The qualifications under paragraph (a) of this section must include qualifications for related services personnel and paraprofessionals that—

(1) Are consistent with any State-approved or State-recognized certification, licensing, registration, or other comparable requirements that apply to the professional discipline in which those personnel are providing special education or related services; and

(2) Ensure that related services personnel who deliver services in their discipline or profession—

(i) Meet the requirements of paragraph (b)(1) of this section; and

(ii) Have not had certification or licensure requirements waived on an

emergency, temporary, or provisional basis; and

(iii) Allow paraprofessionals and assistants who are appropriately trained and supervised, in accordance with State law, regulation, or written policy in meeting the requirements of this part to be used to assist in the provision of special education and related services under this part to children with disabilities.

(c) *Qualifications for special education teachers.* The qualifications described in paragraph (a) of this section must ensure that each person employed as a public school special education teacher in the State who teaches in an elementary school, middle school, or secondary school is highly qualified as a special education teacher by the deadline established in section 1119(a)(2) of the ESEA.

(d) *Policy.* In implementing this section, a State must adopt a policy that includes a requirement that LEAs in the State take measurable steps to recruit, hire, train, and retain highly qualified personnel to provide special education and related services under this part to children with disabilities.

(e) *Rule of construction.* Notwithstanding any other individual right of action that a parent or student may maintain under this part, nothing in this part shall be construed to create a right of action on behalf of an individual student or a class of students for the failure of a particular SEA or LEA employee to be highly qualified, or to prevent a parent from filing a complaint about staff qualifications with the SEA as provided for under this part.

(Approved by the Office of Management and Budget under control number 1820-0030)

(Authority: 20 U.S.C. 1412(a)(14))

##### § 300.157 Performance goals and indicators.

The State must—

(a) Have in effect established goals for the performance of children with disabilities in the State that—

(1) Promote the purposes of this part, as stated in § 300.1;

(2) Are the same as the State's objectives for progress by children in its definition of adequate yearly progress, including the State's objectives for progress by children with disabilities, under section 1111(b)(2)(C) of the ESEA, 20 U.S.C. 6311;

(3) Address graduation rates and dropout rates, as well as such other factors as the State may determine; and

(4) Are consistent, to the extent appropriate, with any other goals and academic standards for children established by the State;

would constitute a violation of the Federal IEP requirements. According to the requirement at 34 CFR § 300.346(a), every IEP must include a "statement of the child's present levels of educational performance." In order to be in compliance with Part B, a local educational agency must satisfy the requirements at 34 CFR § 300.346(a).

According to requirements in the Education Department General Administrative Regulations (EDGAR), at 34 CFR § 76.780-76.783, if you feel that a local educational agency is violating Part B requirements, you can submit a written complaint to the State educational agency (SEA). In California, you can send a complaint to the SEA official at the following address:

Dr. Patrick Campbell  
Assistant Superintendent and Director of Special Education  
California Department of Education  
721 Capitol Mall  
P.O. Box 944272  
Sacramento, California 94244-2720

Copies of the EDGAR complaint procedures and the Part B regulations are enclosed for your information. I hope that this information is helpful.

Judy A. Schrag  
Director  
Office of Special Education Programs

Daniel J. Rose, Esq.  
Drummond, Woodsum, Plimpton & MacMahon  
Attorneys at Law  
245 Commercial Street  
Portland, ME 04101-1117

#### Digest of Inquiry (April 19, 1991)

- May a school district require a parent of a child with disabilities to file a Medicaid claim to recover the cost of special education services?
- Does the accessing of Medicaid to pay for special education services alter, in any way, a school district's obligations under Part B?

#### Digest of Response (September 19, 1991)

##### *School Districts May Use Medicaid as Funding Source*

A school district may access private insurance and Medicaid sources to pay for the cost of special education services; however, the use of a parent's insurance proceeds must be voluntary in circumstances where the parent would be likely to incur a

realistic threat of financial loss. Moreover, the school district may not condition the provision of special education services on parental consent to the filing of an insurance claim, including a claim to be filed with the State Medicaid agency. \*

#### *Use of Medicaid Funds Does Not Alleviate Part B Obligations*

Despite the use of Medicaid funds to pay for the costs of special education services, a school district remains obligated under Part B to provide special education and related services in conformity with a child's IEP, to place a child according to the placement and least restrictive environment requirements, and to provide the requisite due process rights and procedural safeguards.

#### Text of Inquiry

I am writing to inquire about two issues concerning the utilization of Medicaid funds to satisfy a public school's obligation to provide a free and appropriate education ("F.A.P.E.") under the Individual with Disabilities Education Act ("I.D.E.A."), 20 U.S.C. § 1400 *et seq.* First, may a public school require a parent or child to permit the school to access Medicaid to provide services required under F.A.P.E.? Second, does the accessing of Medicaid in any way alter the public school's obligations or rights under I.D.E.A.?

Thank you for your time and consideration.

#### Text of Response

This is in response to your letter in which you request clarification of the circumstances under which public agencies may access Medicaid payments to pay for the cost of required special education and related services.

In 1980, the Department published a Notice of Interpretation on Use of Insurance Proceeds (NOI), published at 45 *Fed. Reg.* 86390 (Dec. 30, 1980). A copy of the NOI, which also is applicable to use of Medicaid payments to pay for the cost of required special education and related services, is enclosed for your information. Your specific questions and the Department's responses follow.

1. May a public school require a parent or child to permit the school to access Medicaid to provide services required under [free appropriate public education (FAPE)]?

Part B of the Individuals with Disabilities Education Act (Part B) requires State educational agencies (SEAs) to assure that FAPE is available to all children with disabilities within specified age ranges. 20 U.S.C. § 1412. The term "free appropriate public education" means special education and related services which (A) have been provided at public expense, under public supervision and direction, and without charge, (B) meet the standards of the State educational agency, (C) include an appropriate preschool, elementary, or secondary school education in the State involved, and (D) are provided in conformity with the individualized education program required under sec-

tion 614(a)(5). 20 U.S.C. § 1401(a)(18). Public agencies, however, in meeting their obligation to provide special education and related services without charge, "may use whatever State, local, Federal and private sources are available in the State to meet the requirements of this part." 34 CFR § 300.301(a). This regulation also provides that "[n]othing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or pay for services provided to a [child with a disability]." 34 CFR § 300.301(b).<sup>1</sup>

Based on the above regulations, it is permissible for school districts to access sources other than Part B funds to pay for the cost of required special education and related services for children with disabilities. However, in the NOI, the Department emphasizes that use of parents' insurance proceeds must be voluntary in circumstances where parents would incur a realistic threat of a financial loss. The NOI explains:

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

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

45 Fed. Reg. 86390 (December 30, 1980).

In addition, public agencies may not condition the provision of special education and related services on parental consent to the filing of an insurance claim. The Part B regulations provide that "[e]xcept for preplacement evaluation and initial placement, consent may not be used as a condition of a benefit to a parent or child." 34 CFR § 300.504(b)(2). Thus, public agencies are not authorized to condition the provision of special education and related services to a child with a disability on a parent's willingness to consent to the filing of an insurance claim, including the filing of a claim with a State Medicaid agency. Therefore, parents may refuse to sign a consent form without jeopardizing receipt of services to their child.

2. Does the accessing of Medicaid in any way alter the public school's obligations or rights under [Part B]?

Under Part B, States and local school districts have an ongoing responsibility to provide FAPE to eligible children determined to have 1 or more of 13 specified disabilities. 20 U.S.C. 1412(2); 34 CFR §§ 300.121 and 300.2. Thus, regardless of whether Medicaid funds are accessed to pay the cost of required special education and related services for children with disabilities, the public agency responsible for educating each child must ensure that the services and program provided to the

child are at no cost to the child and the child's parents in accordance with the child's individualized education program (IEP), and that the other rights and procedural protections in Part B are extended to the child and the child's parents. These include the provision of special education and related services in conformity with an IEP developed and implemented in accordance with §§ 300.340-300.349; placement of the child in accordance with the placement and least restrictive environment requirements of §§ 300.550-300.554 and 300.533; and the provision of the due process rights and other procedural safeguards guaranteed by §§ 300.500, 300.502-300.514, 20 U.S.C. 1415(d)(4) and 20 U.S.C. 1415(e)(4).

I hope the above information has been helpful. If we can be of further assistance, please let me know.

Robert R. Davila  
Assistant Secretary

<sup>1</sup> A statutory amendment to Part B made by the Education of the Handicapped Act Amendments of 1986 recognizes the importance of Medicaid funds in paying the cost of required special education and related services for children eligible under both programs. See 20 U.S.C. § 1413(e). The Department's regulation implementing this statutory requirement provides:

This part may not be construed to permit a State to reduce medical and other assistance available to [children with disabilities], or to alter a [child with a disability's] eligibility, under Title V (Maternal and Child Health) or Title XIX (Medicaid) of the Social Security Act, to receive services that are also part of a free appropriate public education.

34 CFR § 300.601.

Dr. Jeffrey V. Osowski  
Director  
Division of Special Education  
New Jersey Department of Education  
CN 500  
Trenton, NJ 08625-0500

**Digest of Inquiry**  
(May 28, 1991)

- May Part B funds be used to pay the salaries of special education teachers whose instructing of children with disabilities in the regular education classroom may provide some incidental benefit to the regular education students?
- What is the minimum time-and-effort system for tracking split-funding?



The Delaware Code (31 Del. C. 520) provides for judicial review of hearing decisions. In order to have a review of the decision expressed below in Court, a notice of appeal must be filed with the clerk (Prothonotary) of the Superior Court within 30 days of the date of the decision. An appeal may result in a reversal of the decision. Readers are directed to notify the DSS Hearing Office, P.O. Box 906, New Castle, DE 19720 of any formal errors in the text so that corrections may be made.

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
DIVISION OF SOCIAL SERVICES

In re: A. G. [REDACTED], a minor

DCIS No.:  
5000703852

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

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

I

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

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

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

<sup>1</sup> 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<sup>2</sup>, the Medicaid Program under Title XIX of the Social Security Act, the "QMB" Program<sup>3</sup> which is a Medicare Program that is partly funded with Medicaid Program money, and the "Delaware Healthy Children Program"<sup>4</sup> 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<sup>5</sup> 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

<sup>2</sup> 29 Del. C. §§ 7932-7935.

<sup>3</sup> Section 17300 DSSM.

Section 18000 DSSM.

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

youngster who receives medical assistance under the DSS Disabled

Children's medical assistance program.<sup>6</sup> She is diagnosed with buccolingual dyspraxia, expressive and receptive language delays and significant articulation problems.

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

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

#### IV

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

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

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

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

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

<sup>7</sup> Diamond State Health Plan, July 27, 1994, Chapter 1-1.

<sup>8</sup> 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 the 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).





UNITED STATES DEPARTMENT OF EDUCATION

OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

JAN 13 2000

Contact Persons  
Names: Camellia Wang  
JoLeta Reynolds  
Telephone: (202)205-5507

OSEP 00-7

**MEMORANDUM**

TO: State Directors of Special Education

FROM: Kenneth R. Warlick *KRW*  
Director  
Office of Special Education Programs

SUBJECT: Enhancing Coordinated Services Systems among LEAs and SEAs

**INTRODUCTION**

The purpose of this Memorandum is to provide guidance on selected provisions of the Individuals with Disabilities Education Act Amendments of 1997 (IDEA '97) and final implementing regulations as they relate to system-wide coordination of services. The IDEA '97 authorizes a number of new provisions designed to allow flexibility and improve results for children with disabilities and to promote more inclusive practices and better coordination of services at the local and State levels. The Department intends to help facilitate a flexible, systematic coordination of services among local and State educational agencies according to the new provisions of IDEA '97.

This memorandum will address the following provisions in the IDEA '97 concerning the enhancement of coordinated services:

1. Coordinated Services System provision found in Section 613(f) (see also 34 CFR §300.244(a));
2. Schoolwide provision found in Section 613(a)(2)(D) (see also 34 CFR §300.234);
3. Statewide Coordinated Services System provisions found in Sections 611(f)(3)(G) and 619(f)(5) (see also 34 CFR §300.370(a)(7) and §301.26(e));
4. Use of Individualized Family Services Plan (IFSP) for Preschool Children provision found in Section 614(d)(2)(B) (see also 34 CFR §300.342(c)); and

5. Obligations Related to and Methods of Ensuring Services provision found in Section 612(a)(12) (see also 34 CFR §300.142).

This memorandum describes and illustrates these five pertinent IDEA '97 provisions.

**A. Coordinated Services Systems**

Circumstances outside the classroom, such as inadequate or substandard nutrition, living conditions, or health care, have an effect on increasing numbers of children, including children with disabilities. Such circumstances may adversely impact on their ability to succeed in school. Under the Coordinated Services System provision of IDEA '97 (Section 613(f)) and the regulation at §300.244, a local education agency (LEA) may use up to 5% of its IDEA, Part B funds to develop strategies to improve the access of eligible children and their families to comprehensive social, health, and education services that can help students succeed in school. Linking public and private agencies to provide these services, LEAs can implement such a coordinated services system by carrying out various activities, as suggested in Section 613(f)(2) and §300.244(b).

One activity could be to improve the effectiveness and efficiency of service delivery, including developing strategies that promote accountability for student results. A second activity could be in the area of service coordination and case management in order to facilitate the linkage of Individualized Education Programs (IEPs) under Part B of IDEA and Individualized Family Services Plans (IFSPs) under Part C of IDEA with individualized service plans under multiple Federal and State programs, such as title I of the Rehabilitation Act of 1973 (vocational rehabilitation), Title XIX of the Social Security Act (Medicaid), and Title XVI of the Social Security Act (supplemental security income). A third could be in the development and implementation of interagency financing strategies for the provision of education, health, mental health and social services, including transition services and related services under IDEA. In addition, interagency personnel development for individuals working on coordinated services could be another activity.

It is important to note that LEAs using Part B funds for Coordinated Services Systems must use these funds in combination with other amounts (which must include amounts other than education funds) to develop and implement a coordinated services system designed to improve results for all children and their families. If an LEA is carrying out a coordinated services project under Title XI of the Elementary and Secondary Education Act (ESEA) of 1965 and a coordinated services project under Section 613(f) of Part B of IDEA in the same schools, the LEA shall use the amounts under IDEA in accordance with the requirements of Title XI of the ESEA.

**B. Schoolwide Programs**

Schoolwide programs are advantageous in that they provide LEAs the opportunity to comprehensively plan the overall educational program for all children in the school; allow LEAs to develop fully integrated services systems to address the needs of students; and offer LEAs an

opportunity to spend Federal resources in ways they determine can most effectively raise the achievement of their students and stimulate comprehensive reform of the entire instructional program. The IDEA '97 under Section 613(a)(2)(D) and the regulation at §300.234(a) authorize local education agencies to use a portion of the funds received under Part B for any fiscal year to carry out a schoolwide program under Section 1114 of the Elementary and Secondary Education Act of 1965. In a schoolwide program, a portion of the Part B funds can be combined with funds from Title I, allowing schools to integrate programs, strategies, and resources.

Schools that have schoolwide projects under Title I are able to plan schoolwide programs that build on schoolwide reform strategies, rather than separate, add-on services; provide flexibility in spending Title I funds in support of the schoolwide program; and focus on results.

### **C. Statewide Coordinated Services System**

Besides the flexibility afforded to LEAs in using IDEA funds, a state can use up to 1% of the amount that it receives under Sections 611(f)(3)(G) and 619(f)(5) of IDEA '97, Part B, and the regulation at §300.370(a)(7) and §301.26(e) to supplement other amounts used to develop a Statewide coordinated services system designed to improve results for children and families. This Statewide coordinated services system must be coordinated with, and, to the extent appropriate, build on the system of coordinated services developed by the State under Part C of IDEA '97.

For example, a LEA that has developed a Statewide coordinated services system under Part C of IDEA provides wraparound services for infants and toddlers with disabilities and their families. The existing system includes all social service, mental health, education, and community agencies in the State. The State can improve its statewide coordinated services systems to serve older children, especially those with emotional disturbance and behavioral problems, by using 1% of the amount it receives under Section 611, along with funds from the other agencies in the Statewide system. In this way, the State has expanded the system to allow for the provision of wraparound services to all disabled children in the mandated age ranges who need such services.

### **D. Use of Individualized Family Service Plans (IFSPs) for Preschool Children**

Development of collaborative early childhood transition systems is increasingly facilitated when State policy makers can enjoy programmatic and fiscal flexibility, as we have seen since 1991. In particular, Section 614(d)(2)(B) of IDEA '97 and the regulation at §300.342(c) authorize States to use Part C and Section 619 funds outside the normal age limitations to provide services to children during the transition from the Early Intervention Program under Part C to Part B. A collaborative transition process also has been supported by allowing States the option of using individualized family service plans (IFSP) to serve as the individualized education programs (IEP) for children with disabilities ages 3 through 5 years, if using that plan as the IEP is consistent with State policy and agreed to by both the agency and the child's parents.

At the foremost, any State opting to allow an IFSP to serve as an IEP must first develop policies and include those policies in their Part B State eligibility document under Section 612 of the IDEA. The option to use an IFSP as the IEP is then available to LEAs, although LEAs are not

required to use IFSPs. The public agency must provide a detailed explanation of the differences between an IFSP and an IEP to parents. Parents and the public agency also have to first decide whether to use an IFSP in lieu of the IEP prior to its use. Furthermore, the public agency is required to obtain written informed consent from parents to use an IFSP. Public agencies, including LEAs and other State agencies, must ensure that if an IFSP serves as the IEP of a child, all the Part B procedures for developing an IEP, including placement decisions, are followed. (see Section 636(d) of IDEA '97; 34 CFR §300.342(d)).

To further elaborate, the option of using an IFSP to provide FAPE to a young child transitioning from early intervention services to preschool special education broadens the range of service delivery models available to children, their parents, and public agencies. Opportunity for multi-agency collaboration exists at the State level with the development of appropriate policies and procedures. States can then include those policies in their statewide early childhood transition systems developed between the SEA and State Part C lead agency.

#### **E. Obligation Related to and Methods of Ensuring Services**

Some states and local school districts are concerned about the costs of services for children with significant health-related needs. Increasing numbers of children and youth with disabilities, especially those with intensive health-related needs, are now attending regular public schools with children in their neighborhoods. The health-related services required by these children have been provided in schools, and for eligible children, some of these services have been paid for through sources such as Medicaid, the new Children's Health Insurance Program (CHIP), or rehabilitation agencies. However, these sources only partially provide or pay for special education and health-related needs.

Further assistance to schools' efforts to collaborate with the health service system, rehabilitation agencies, assistive technology providers, mental health agencies, and other organizations that provide and pay for services for children and youth with disabilities, including those with intensive health-related needs, is provided in Section 612(a)(12) of IDEA '97 and the regulation at §300.142. These sections specifically require that States establish written interagency agreements or other mechanisms that delineate methods for providing and paying for needed services such as assistive technology devices, transition services, and many health-related services such as occupational and physical therapy.

To alleviate the considerable administrative burden on schools and ensure consistency within States, the IDEA '97 also places the burden of negotiating with Medicaid, CHIP, rehabilitation agencies and other agencies for services and reimbursement on the Chief Executive Officer in each state. The Governor or his or her designee is responsible for ensuring that States have such interagency agreements or other mechanisms in place between the State educational agency and other public agencies.

Specifically, in any of the Interagency Agreements or other mechanisms, the following must be included: (1) an identification of, or a method for defining, the financial responsibility of each agency for providing services to ensure a free appropriate public education (FAPE) for children with disabilities; (2) the conditions, terms, and procedures under which a local education agency

will be reimbursed for such services by other agencies; (3) procedures for resolving interagency disputes and methods by which local educational agencies may initiate action to secure payment; and (4) policies and procedures for agencies to determine and identify the interagency coordination responsibilities of each agency to promote the coordination and timely and appropriate delivery of services.

In addition, Section 612(a)(12)(B) of IDEA '97 details the financial obligations of noneducational public agencies involved in interagency agreements. If a public agency other than an educational agency is otherwise obligated under law, or assigned responsibility under State policy, interagency agreement, or other mechanism to provide or pay for services that are considered special education or related services for children with disabilities within the State, it may provide that service directly, through contract, or through another arrangement. If the public agency fails to provide or pay for the special education or related services, the local education agency (LEA) or State agency responsible for developing the child's IEP must provide and pay for the services to the child in a timely manner. Thereafter, the LEA or State agency may claim reimbursement for the services from the public agency that failed to provide or pay for such services. The public agency may fulfill this obligation or responsibility either directly, through contract, or other arrangement. The methods for doing this must be specified in the interagency agreement.

The law also clearly states that the State Medicaid agency, as well as other public insurers of children with disabilities, shall precede the financial responsibility of the local education agency (or State agency). The form of the interagency agreements--whether they be a State statute or regulation, a signed agreement between agency officials, or other appropriate methods--is left to the discretion of the Chief Executive Officer or his or her designee. In any event, the agreement still must be in writing.

In sum, these five provisions of the IDEA '97 allow flexibility in and improve the coordination of services at both state and local levels. I hope this document will provide guidance and encourage SEA and LEA personnel to develop and implement coordinated services systems.

For further assistance on these provisions, please contact the person(s) listed on the front of this memo or you may ask to speak with the OSEP State contact for your state.

Thank you.

cc: State Medicaid Directors  
Title V (Children with Special Health Care Needs) Directors  
RSA Regional Commissioners  
Regional Resource Centers  
Federal Resource Center  
Special Interest Groups  
Parent Training Centers  
Independent Living Centers  
Protection and Advocacy Agencies

Explicit parental consent to “tap” Medicaid should be required. See attached federal guidance referring to a “consent form” and requirement that “parental consent” must be obtained “each time that access to public benefits or insurance is sought”. Characterizing consent to an annual IEP as consent to accessing Medicaid for PDN does not conform to this federal guidance. Even on a practical level, PDN can change more frequently than an annual IEP (§5.2.2).

Ninth, §5.2.6 contains an incorrect legal standard for eligibility to use Medicaid to fund school-based services. The standard refers to a determination that “a school is unable to meet the medical needs of school age children who are technology dependent or for whom DMAP has determined these services to be otherwise medically necessary”. [emphasis supplied] There are two problems with the underlined provision.

A. A child could qualify for PDN for reasons apart from technological dependency.

B. Medicaid is expected to routinely fund qualifying services in schools. A school is not required to demonstrate that it cannot meet a child’s needs without resorting to Medicaid funding. See attached In re A.G., DCIS No. 5000703852 (DHSS June 22, 2000); U.S. DOE Memorandum, OSEP 00-7 (January 13, 2000), at 5 [“The law clearly states that the State Medicaid agency, as well as other public insurers of children with disabilities, shall precede the financial responsibility of the local educational agency (or State agency)”].

The Councils may wish to share the above observations with DMMA. The GACEC may wish to highlight the “Ninth” observation in a separate communication to the DOE.

Attachments

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