



# DISABILITIES LAW PROGRAM

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## MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory Initiatives

Date: November 14, 2015

Consistent with the requests from the SCPD and GACEC, I am providing an analysis of thirteen (13) regulatory initiatives. Given time constraints, the analysis should be considered preliminary and non-exhaustive.

### 1. DPH Final Medical Marijuana Regulation [19 DE Reg. 409 (11/1/15)]

The SCPD and GACEC commented on the proposed version of this regulation in August, 2015. A copy of the August 26 SCPD letter is attached for facilitated reference. The Division of Public Health has now adopted a final regulation incorporating some amendments prompted by the commentary.

First, the Councils supported access to marijuana oil for covered adults and questioned whether the existing language precluded such access. The Division clarified that adult access to marijuana oil is available and no amendments are necessary.

Second, the Councils questioned whether the 3 oz cap on usable marijuana should apply to both dried plant product and oil. The Division clarified that the calculation for oil is expressed in milligrams (mg.). Since there are 15 mg of active ingredient per milliliter of oil, a 3 ml syringe would contain 45 mg of active ingredient. Since there are 28,350 mg. in an ounce, there are 85,350 mg in 3 ounces. Therefore, a covered user could obtain 1,897 3 ml syringes per 14-day period. The 3 oz cap should obviously not be a problem when applied to oil.

Third, the Councils recommended an amendment to correct grammar. The Division adopted the recommended amendment verbatim.

Fourth, the Councils recommended an amendment to clarify that a prescribing pediatric physician would only be necessary for patients under the age of 18. The Division adopted a conforming amendment.

Fifth, the Councils noted that the term “seizures” had been omitted as a symptom in §3.3.3.2. The Division inserted the term.

Sixth, the Councils recommended an amendment to correct grammar. The Division adopted a conforming amendment.

Seventh, the Councils recommended an amendment to correct grammar. The Division adopted the recommended amendment verbatim.

Eighth, the Councils endorsed adoption of more flexible standards on compassion center inventory. The Division acknowledged the endorsement.

Ninth, the Councils suggested consideration of removing limits on amounts of medical marijuana. The Division responded that the limits are statutory.

Since the regulation is final, and the Division responded to each comment, I recommend either no action or a “thank you” communication.

2. DOE Proposed Emergency Certificate Regulation [19 DE Reg. 367 (11/1/15)]

The Professional Standards Board of the Department of Education proposes to adopt some discrete amendments to the “emergency certificate” regulation. The rationale for the changes is as follows: “This regulation is being amended to provide current formatting and to eliminate unnecessary language, as well as to allow the Department of Education the ability to process some Emergency Certificates automatically for those enrolled in an approved Alternate Routes program.”

I have the following observations.

First, the Department is striking the current requirement (§4.1.4) that an application for an Emergency Certificate include a written plan outlining how the applicant intends to meet certification requirements. The DOE may wish to reconsider this deletion for the following reasons:

A. Section 3.7. still refers to the plan.

B. Substantively, it would be valuable to have a plan “verified by the individual and the employing authority” so everyone is “on the same page” with respect to steps needed to achieve regular certification. It would also be useful to the DOE to have such a plan so it could review progress (or lack of progress) when someone files a renewal application..

Second, there are inconsistencies in the duration of the Emergency Certificate. On the one hand, two sections indicate that the Emergency Certificate is valid for a single school year:

3.1.1. An Emergency Certificate is valid for one school year subject to a limited extension as indicated herein.

3.1.2. The Emergency Certificate is issued by a particular school year and expires on June 30<sup>th</sup> unless a limited extension is granted.

On the other hand, two sections contemplate a 2-year duration to the Emergency Certificate:

3.8.1. The Emergency Certificate may be valid for up to two (2) consecutive school years. An employing authority must request an extension of the Emergency Certificate prior to ~~June 30<sup>th</sup>~~ November 1<sup>st</sup>.

3.8.2. Emergency Certificates granted an extension shall expire on June 30<sup>th</sup> fo the consecutive school year.

This is confusing. Consider the following.

A. If an educator has a 1-year Emergency Certificate, could the educator apply for an additional 2 years in duration (aggregating 3 years) or is the “two consecutive school years” the cap? Since §3.6 contemplates a 3 year duration for persons enrolled in the “alternative routes” program, I suspect the DOE intends to authorize an aggregate 3-year cap.

B. It is counterintuitive to have certificates expire on June 30 and allow requests for “extensions” to be filed by November 1, more than 4 months later, nunc pro tunc. If a certificate expired more than 4 months ago, it is “odd” to characterize an application for the next school year as an “extension”. The DOE may wish to consider adopting the term “renewal”.

Third, although not earmarked for amendment, §§3.8.4.2 and 5.1.1 still refer to the “DPAS”. The DOE may wish to revise those references since “DPAS II” is now applicable. See 14 DE Admin Code 106A.1.0.

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

### 3. DOE Prop. Educational Records Transfer & Maintenance Reg. [19 DE Reg. 355 (11/1/15)]

The Department of Education proposes to adopt some discrete amendments to its standards covering the transfer and maintenance of student records. Most of the changes are minor or benign.

The most significant clarification is the treatment of records when students transfer between schools. See §§3.2.1.1 and 3.2.1.2. First, if a student transfers from a public school to either a private school or DSCY&F educational program, the public school keeps the original cumulative file while sending a copy to the receiving private school or DSCY&F program. Second, if a student transfers from a public school to another public school, the original cumulative file is sent to the receiving public school. This is ostensibly a reasonable approach. The only caveat is that there could be ambiguity if a student transfers to an out-of-state “public school”. There is no definition of “public school” and it might be prudent for the Delaware public school to retain at least a copy of the cumulative file sent to an out-of-state public school so there is a Delaware record. Otherwise, if the out-of-state school loses the record, and the student seeks to document his/her education in Delaware, there would be no Delaware cumulative record for reference.

The Councils may wish to consider an endorsement subject to DOE review of the practice for students transferring to an out-of-state public school.

#### 4. DOE Proposed Medications & Treatments Regulation [19 DE Reg.362 (11/1/15)]

The Department of Education proposes to amend its regulation covering assistance with self- administration of medications at approved school activities.

As background, it is settled law that public schools must provide healthcare accommodations to facilitate participation of students with disabilities on field trips and school-sponsored events. The Delaware Attorney General’s Office issued the attached opinion in 1994 highlighting that obligation. In 2000, the Legislature enacted legislation (S.B. No. 382), authored by Sen. Blevins, to authorize trained educators to assist students with self-administration of medications on field trips. In 2012, the Legislature enacted legislation (S.B. No. 257), authored by Sen. Hall-Long, which expanded the law to permit trained coaches and persons under contract to assist with medications in approved school activities outside the traditional school day or off-campus. See attachment.

The Department of Education never fully implemented S.B. No. 257, restricting assistance with medications to “employees” and excluding contractors. See attached regulation, 19 DE Reg. 362, 363, §6.1 (November 1, 2015).

The Department is now proposing a regulation to allow public schools to adopt exemptions from the above system:

6.2 . District and charter school boards may develop policies for unique Approved School Activities for which the specified process is unable to be implemented.

The DOE envisions such exemptions applying to “extended field trips”:

This regulation is amended to clarify assistance with self-administration of medications at unique approved school activities, such as extended field trips...

At 362.

This “exemption” authorization is ill-conceived,, undermines the intent of the above of State legislation, and invites non-compliance with federal law. Given the reference to “extended” field trips, I infer that the justification for this initiative is based on cost concerns or limited availability of trained employees. These are insufficient reasons to authorize exemptions from providing medication support to students.

A U.S. Supreme Court decision is instructive. In Cedar Rapids Community School District v. Garret, 526 U.S. 66 (1999) (copy attached), the Supreme rejected a “cost defense” to a district’s obligation to provide continuous one-to-one nursing services to a ventilator dependent student paralyzed from the neck down. If a school district can be required to provide continuous 1:1 nursing care to a student, it is difficult to imagine a scenario in which a district could legally decline to provide medication support for an “extended field trip”. Districts can utilize a school nurse, a trained employee, or a trained contractor to facilitate a student’s participation in off-campus activities. If a district has insufficient trained personnel, it can hire a nurse to provide medication assistance in the activity.

The Councils may wish to consider opposition. The Councils may also wish to consider the merits of informing policymakers, including the Attorney General.

5. DPH Proposed Personal Assistance Services Agency Reg. [19 DE Reg. 392 (11/1/15)]

Legislation (H.B. No. 107) ) was recently enacted to remove a ban on provision of personal assistance services in hospitals and nursing facilities. The Division of Public Health is now proposing regulations to implement the law. A public hearing is scheduled to occur on December 2, 2015.

The preamble describes the purpose of the changes as follows:

One purpose of the amendments to allow for the provision of services by these agencies in nursing facilities and hospitals. This change will allow consumers to receive the services necessary to safely achieve their highest level of independence and optimal quality of life while residing in their own home or during a necessary hospitalization. In addition, amendments were made to update the requirements to ensure patients receive safe and quality care.

At 392.

In general, the Division is proposing discrete rather than wholesale revisions to existing standards. I have only four observations.

First, in §1.0, definition of "Personal Assistance Services Agency", first sentence, I recommend correction of grammar. There are singular pronouns (his/her) with a plural antecedent (consumers). This can be easily corrected by substituting "their" for "his/her".

Second, in §1.0, definition of "Personal Assistance Services Agency", the second sentence reads as follows: "The personal assistance services agency shall only provide services in the county in which the agency is located and/or the county(ies) which are immediately adjacent." This new limitation may be ill-conceived. A "Personal Assistance Services Agency" "located" in Kent County could serve the entire State. However, an Agency "located" in NCC could not serve clients in Sussex and an Agency "located" in Sussex could not serve clients in NCC. The rationale for this change is not provided. The term "located" is not defined. It is not based on statute. See 16 Del.C. §122(3)x. Delaware is a small state and the limitation may unnecessarily circumscribe residents' choice of providers.

Parenthetically, inclusion of this limitation in a definition violates the attached Section 4.3 of the Delaware Administrative Code Style Manual since it creates a substantive standard in a definition.

Third, in §5.4.2.2, simple fingernail care by a direct care worker is authorized. However, toenail care is categorically banned. This is counterintuitive. If someone can trim a fingernail, the same skills would logically apply to trimming toenails. For example, simple "soaking of fingernails" is authorized but soaking of toenails is banned. Moreover, the ban would ostensibly conflict with the statutory authorization that authorizes personal assistance workers to provide "those other services set out in §1921(a)(15) of Title 24", i.e. acts individuals would normally perform themselves but for functional limitations. [16 Del.C. §122(3)x2]. Individuals could normally provide their own toenail care. The Division may wish to consider whether a categorical ban on toenail care is justified.

Fourth, the following new limitation is added:

Section 3.13. The personal assistance services agency must not use the word "healthcare", or any other language that implies or indicates the provision of healthcare services, in its title or in its advertising.

Since personal assistance workers, by statute, can perform acts individuals could normally perform themselves but for functional limitations, the restriction is "overbroad". See 16 Del.C. §122(3)x2 and 24 Del.C. §1921(a)15). Many of the services authorized by statute would amount to "healthcare". Indeed, the above statutes specifically authorize personal care workers to perform "healthcare acts".

The Councils may wish to consider sharing the above observations with the Division. The SCPD may also wish to consider sharing a courtesy copy of the observations with the State Chamber of Commerce.

6. DPH Prop. Skilled Home Health Agency Licensure Reg. [19 DE Reg. 391 (11/1/15)]

Legislation (H.B. No. 107) ) was recently enacted to remove a ban on provision of home health agency services in hospitals and nursing facilities. The Division of Public Health is now proposing regulations to implement the law.

The preamble describes the purpose of the changes as follows:

One purpose of the amendments to allow for the provision of services by these agencies in nursing facilities and hospitals. This change will allow consumers to receive the services necessary to safely achieve their highest level of independence and optimal quality of life while residing in their own home or during a necessary hospitalization. In addition, amendments were made to update the requirements to ensure patients receive safe and quality care.

At 392.

In general, the Division is proposing discrete rather than wholesale revisions to existing standards. I have only one observation.

In §1.0, definition of “Home Health Agency (HHA)”, the second sentence reads as follows: “The HHA shall only provide services in the county in which the HHA is located and/or the county(ies) which are immediately adjacent.” This new limitation may be ill-conceived. An HHA “located” in Kent County could serve the entire State. However, an Agency “located” in NCC could not serve clients in Sussex and an Agency “located” in Sussex could not serve clients in NCC. The rationale for this change is not provided. The term “located” is not defined. It is not based on statute. See 16 Del.C. §122(3). Delaware is a small state and the limitation may unnecessarily circumscribe residents’ choice of providers.

Parenthetically, inclusion of this limitation in a definition violates the attached Section 4.3 of the Delaware Administrative Code Style Manual since it creates a substantive standard in a definition.

The Councils may wish to consider sharing the above observations with the Division. The SCPD may also wish to consider sharing a courtesy copy of the observations with the State Chamber of Commerce.

7. DPH Prop. Home Health Aide Only Agency Licensure Reg. [19 DE Reg. 391 (11/1/15)]

Legislation (H.B. No. 107) ) was recently enacted to remove a ban on provision of home health agency services in hospitals and nursing facilities. The Division of Public Health is now proposing regulations to implement the law.

The preamble describes the purpose of the changes as follows:

One purpose of the amendments to allow for the provision of services by these agencies in nursing facilities and hospitals. This change will allow consumers to receive the services necessary to safely achieve their highest level of independence and optimal quality of life while residing in their own home or during a necessary hospitalization. In addition, amendments were made to update the requirements to ensure patients receive safe and quality care.

At 388.

In general, the Division is proposing discrete rather than wholesale revisions to existing standards. I have only one observation.

In §1.0, definition of “Home Health Agency (HHA)”, the second sentence reads as follows: “The HHA shall only provide services in the county in which the HHA is located and/or the county(ies) which are immediately adjacent.” This new limitation may be ill-conceived. An HHA “located” in Kent County could serve the entire State. However, an Agency “located” in NCC could not serve clients in Sussex and an Agency “located” in Sussex could not serve clients in NCC. The rationale for this change is not provided. The term “located” is not defined. It is not based on statute. See 16 Del.C. §122(3)o. Delaware is a small state and the limitation may unnecessarily circumscribe residents’ choice of providers.

Parenthetically, inclusion of this limitation in a definition violates the attached Section 4.3 of the Delaware Administrative Code Style Manual since it creates a substantive standard in a definition.

The Councils may wish to consider sharing the above observations with the Division. The SCPD may also wish to consider sharing a courtesy copy of the observations with the State Chamber of Commerce.

8. DMMA Prop. Medicaid Outpatient Drug Reimbursement Reg. [19 DE Reg. 369 (11/1/15)]

The Division of Medicaid & Medical Assistance (DMMA) proposes to adopt some discrete changes to its reimbursement standards for prescription drugs.



As background, federal law authorizes states to negotiate rebate agreements with drug manufacturers. Federal law (340B program) also requires drug manufacturers to enter into agreements with HRSA to provide discounts on drugs to covered entities. The interplay of these laws is complicated. However, State Medicaid agencies must exclude from State rebate requests drugs that have already by discounted under the 340B program:

State Medicaid agencies should exclude claims for 340B purchased drugs (340B claims) from Medicaid rebate requests to prevent subjecting drug manufacturers to duplicate discounts (i.e. selling 340B-purchased drugs to covered entities at the discounted ceiling prices and providing Medicaid rebates on the same drugs).

At 371.

In practice, drug manufacturers are contesting State rebate requests based on their perception that the drugs have already been discounted under the 340B program. DMMA recites as follows:

Drug manufacturers use the potential for a 340B discounted price to dispute rebate payments.

At 371.

DMMA has determined that its providers do not generally use 340B discounted drugs for Medicaid patients:

To date, with few exceptions, every contracted entity listed on the 340B participating providers' file has responded in writing that they do not use these products for Delaware Medicaid patients.

At 371.

To obviate drug manufacturer argument, DMMA is amending the State Plan to categorically bar providers from using 340B discounted drugs for Medicaid patients:

Entities that purchase Section 340B of the Public Health Services products are prohibited from using their stock for DMAP patients either directly or through coverage of the Managed Care Organization.

At 373.

Since the proposal should remove an impediment to drug manufacturer rebate payments to the State, the Councils may wish to consider an endorsement.

10. DMMA Prop. EPSDT Inpatient Psych Hospital Services Reg. [19 DE Reg. 380 (11/1/15)]

The Division of Medicaid and Medical Services (DMMA) proposes to amend the Medicaid State Plan in the context of coverage and reimbursement methodology for psychiatric residential treatment facilities.

As background, the Division notes that federal EPSDT standards require State Medicaid programs to offer a comprehensive array of services for individuals under age 21. In the mental health and substance abuse contexts, such services include "rehabilitative services" and "inpatient psychiatric services for individuals under age 21". At 381-383. On February 23, 2011, CMS sent DMMA a letter sharing concerns with the Division's monthly bundled rates for rehabilitative child mental health and substance abuse services under the EPSDT program. At 383. Moreover, CMS issued the attached bulletin in 2012 which increased flexibility in covering costs of services to persons under age 21 in inpatient psychiatric facilities.

DMMA is now implementing the CMS guidance by adopting a Medicaid State Plan Amendment based on a CMS template. The amendment results in no increase in costs to the General Fund. At 384.

I did not identify any technical concerns with the State Plan Amendment. Moreover, since it is based on a CMS template, DMMA is rarely amenable to revision of such initiatives.

The Councils may wish to consider endorsement since the changes are prompted by the need to conform to CMS guidance, increase flexibility, and result in no cost in GF to the State.

11. DMMA Prop. EPSDT Mental Health Services Reg. [19 DE Reg. 373 (11/1/15)]

The Division of Medicaid and Medical Services (DMMA) proposes to amend the Medicaid State Plan in the context of coverage and reimbursement methodology for rehabilitative mental health services.

As background, the Division notes that federal EPSDT standards require State Medicaid programs to offer a comprehensive array of services for individuals under age 21. At 374. In the mental health and substance abuse contexts, such services include "rehabilitative services". On February 23, 2011, CMS sent DMMA a letter sharing concerns with the Division's monthly bundled rates for rehabilitative child mental health and substance abuse services under the EPSDT program. At 375. In response, DMMA proposes to add clarifying language to the Medicaid State Plan through the following:

- 1) defining the reimbursable unit of service;
- 2) describing payment limitations;
- 3) providing a reference to the provider qualifications; and
- 4) publishing the location of State fee schedule rates.

At 375.

For unlicensed providers, DMMA proposes to adopt the same rate setting methodology applied to the PROMISE program. Id.

The Division anticipates “no increase in cost on the General Fund” but a significant federal budget impact, i.e., \$837,865.32 in FFY17. The logical inference is that the changes will result in drawing down considerable federal matching funds.

I have the following observations.

First, in §4.b., Att 3.1-A, Page 2c Addendum, the text categorically requires school provided services to be included in an IEP/IFSP. I have 2 concerns in this context:

A. Many students with disabilities have Section 504 plans, not an IEP or IFSP. If CMS standards do not categorically require Medicaid services in schools to be listed in an IEP/IFSP, it would be preferable to remove this limitation.

B. There may be students with acute, but short-term disabilities (e.g. PTSD from child abuse) who will not qualify for classification under the IDEA. However, the school may wish to provide mental health services given the acute nature of the disability. It would be preferable to allow Medicaid billing under these circumstances.

Second, in Attachment 3.1-A, Page 2d Addendum, DMMA proposes to strike an authorization to cover “any other medical or remedial care provided by licensed medical providers as authorized under 42 CFR 440.60...” No rationale is provided for striking the provision. I recommend retention.

Third, several sections require a covered service to be “face to face”. See, e.g., Attachment 3.1-A, Page 2e.5 Addendum, Psychosocial Rehabilitation; Attachment 3.1-A, Page 2.e.7 Addendum, Crisis Intervention; Attachment 3.1-A, Page 2.e.9 Addendum, Crisis Intervention and Family Peer Support. There is some “tension” between these categorical limitations and the DMMA State Plan Amendment authorizing any Medicaid-funded services to be provided via telemedicine. See 18 DE Reg. 227 (September 1, 2014).

Fourth, there are multiple sections requiring a provider to be at least 21 years old. See, e.g., Attachment 3.1-A, Page 2e.6 Addendum, Psychosocial Rehabilitation; Attachment 3.1-A, Page 2e7 Addendum, Crisis Intervention; Attachment 3.1-A, Page 2e10 Addendum, Family Peer Support; Attachment 3.1-A, Page 2e.16 Addendum, Direct Care Staff. This ostensibly violates the regulations to the federal Age Discrimination Act, 45 CFR Part 91, which limits age discrimination in federally funded programs. If an adult meets licensing, degree, or skill-set standards, age is not a sustainable basis to bar qualifying as a federally funded provider.

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

12. DMMA Prop. EPSDT Substance Use Disorder Reg. [19 DE Reg. 377 (11/1/15)]

The Division of Medicaid and Medical Services (DMMA) proposes to amend the Medicaid State Plan in the context of coverage and reimbursement methodology for Medicaid rehabilitative substance use disorder services.

As background, the Division notes that federal EPSDT standards require State Medicaid programs to offer a comprehensive array of services for individuals under age 21. At 378. On February 23, 2011, CMS sent DMMA a letter sharing concerns with the Division's monthly bundled rates for rehabilitative child mental health and substance abuse services under the EPSDT program. At p. 379. In response, DMMA proposes to add clarifying language to the Medicaid State Plan in through the following:

- 1) defining the reimbursable unit of service;
- 2) describing payment limitations;
- 3) providing a reference to the provider qualifications; and
- 4) publishing the location of State fee schedule rates.

At 379.

The changes are highly prescriptive and detailed. The scope of covered practitioners is bewildering. The regulation includes standards covering the following, among others:

Licensed Clinical Social Workers (LCSWs);  
Licensed Professional Counselors of Mental Health (LPCMHS);  
Licensed Marriage and Family Therapists (LMFTs);  
Licenced Chemical Dependency Professionals (LCDPs);  
Certified Recovery Coaches;  
Credentialed Behavioral Health Technicians;  
Certified Alcohol and Drugs Counselors (CADCs);  
Internationally Certified Alcohol and Drug Counselors (ICADCs); and  
Certified Certified Co-occurring Disorders Professionals (CCDPs).

In general, reimbursement rates will be the same for public and private providers and not be less than the maximum allowable rate under the Medicare program.

I did not identify any significant issues in reviewing the 10 pages of revised standards. However, without ample background in substance abuse treatment finances, licensing, certification, and programming, it may be imprudent to issue a general endorsement. The Councils may wish to consider issuing a comment based on the following: 1) acknowledgment of review; 2) observation of highly prescriptive standards; and 3) lack of identification of obvious shortcomings.

13. DPH Proposed DMOST Regulation [19 DE Reg. 388 (11/1/15)]

Laura Waterland, a DLP Supervising Attorney, prepared the following analysis of the proposed DMOST regulation:

## **MEMO**

**To:** State Council for Persons with Disabilities, Kyle Hodges  
**From:** Laura J. Waterland, Supervising Attorney  
**Subject:** Proposed Regulations implementing Delaware Medical Orders for Scope of Treatment/ 16 DE Admin. Code 4304  
**Date:** November 14, 2015

**I am responding to a solicitation from the SCPD Policy and Law Committee for technical assistance regarding recently published proposed regulations implementing HB 400, Delaware Medical Orders for Scope of Treatment (“DMOST”). The DMOST bill creates a new Title 25A which outlines the context and the mechanics for creating a DMOST by patients, their representatives, and health care providers.**

**A DMOST is a clinical process in which patients, with serious, advanced illness or frailty, or their authorized representatives if they lack decision-making capacity, discuss and have reduced to a medical order their goals of care and treatment choices. The DMOST order must be signed by the patient or representative, and a health care practitioner, in order to be valid. The DMOST is not meant to supplant advance health care directives (“AHCD”); rather it is meant to address a more immediate need for a medical order reflecting current goals and treatment choices that can be followed by emergency medical personnel and treatment providers in multiple settings. AHCDs are of limited utility in emergency situations, situations where people are transferring frequently between locations (home, nursing home, hospital) or situations where the AHCD doesn’t address a specific medical decision that has to be made.**

**The regulations mirror the statutory language in large measure and I do not have any serious concerns. The most important feature is the promulgation of the form and plain language statement, which are the only forms that can be used. My specific comments are:**

### **1.0 Definitions.**

**“Advance health care directive.” The definition seeks to clarify that AHCDs that are valid where executed are to be honored in Delaware. However, the regulatory definition adds the phrase “valid under Delaware law” to the statutory definition, and the language suggests that the only out of state AHCDs that are recognized in Delaware are ones that are valid where executed and in Delaware. This requirement would prove unworkable and is inconsistent with the statutory language in 16 Del Code §2503A(a) and of 16 Del. Code §2517, which plainly states that AHCDs valid where executed are honored in Delaware, whether they strictly comport to Delaware law or not.**

Section 4.0 is sort of a catch-all section for a number of important principles:

Section 4.7 addresses situations where a person has decision-making capacity but is unable to communicate by speaking or writing. In those circumstances, the person is allowed to communicate through the method by which they usually communicate, so long as the person interpreting understands that method, and this must be documented in the medical record.

There is always a concern in these circumstances that the person interpreting is actually doing so and not substituting their own words or wishes. The requirement that there be a notation in the chart is something of a safeguard. However, it would be appropriate to add a requirement that there be a witness to this communication, and that a health care practitioner has noted some indicia of reliability regarding the interpreter's ability to understand what is being communicated.

Additionally, this section does not and cannot eliminate the requirement under the ADA or state law that a health care facility provides effective communication for people with communication impairments. This should be stated in the regulation. It would be unfortunate for this regulation to be used to deny qualified interpreters when they are required, and sanction the use of lay interpreters or family members, which is often inappropriate.

#### **DMOST Form and Directions:**

In the DMOST form, in the first bullet point section, an "s" is needed in bullet 4 at the end of "measure." In Section E, it is unclear who is signing on the line to the immediate right. You have to check the directions to be sure. Additionally, the line regarding whether an appointed representative can alter a DMOST should be set off in some fashion, either by bolding or by line. It very much gets lost in the rest of the box, and it is a very significant designation. They might consider doing a yes/no box format, or adding it to Box F.

Attachments

E:legis/1115bils  
F:pub/bjh/leg/2015P&L/1115bils



STATE OF DELAWARE  
STATE COUNCIL FOR PERSONS WITH DISABILITIES  
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August 26, 2015

Ms. Jamie Mack  
Division of Public Health  
Jesse Cooper Building  
417 Federal Street  
Dover, DE 19901

RE: 19 DE Reg. 91 [DPH Emergency Medical Marijuana Regulation] and 18 DE 116 [DPH Proposed Medical Marijuana Regulation]

Dear Ms. Mack:

The State Council for Persons with Disabilities (SCPD) has reviewed the Division of Public Health's (DPH's) proposal to adopt some discrete amendments to the State of Delaware Medical Marijuana Code. The new standards appear in the August 1, 2105 Register of Regulations as both an emergency regulation at 19 DE Reg. 91 and proposed regulation at 19 DE Reg. 116. The primary impetus for the revisions is the recent enactment of S.B. 90. Background on that legislation is contained in the attached May 14, 2015 News Journal article and summary published in the Delaware Senate Republican Caucus newsletter. As these sources indicate, the primary focus of the legislation was to amend the medical marijuana law to allow children under age 18 to use medical marijuana-based oils to treat seizures.

SCPD has the following observations.

First, it would be preferable to permit an adult with a qualifying condition to receive marijuana oil as juxtaposed to traditional dried-plant-based marijuana. The regulation ostensibly disallows adults from acquiring marijuana oil. See §7.2.8.3.1.4. Indeed, it is defined as "Pediatric Medical Marijuana Oil". Consider the following:

- A. Ingesting an oil would not have the adverse lung effects of smoking marijuana.
- B. A minor turning 18 for whom the oil is effective must categorically stop using the oil. See §5.3.8. It is difficult to imagine that the efficacy of the oil would change on someone's birthday.
- C. The May 14, 2015 article suggests that other states allow adults access to the oil-based marijuana:

Fourteen states have approved cannabis oil for the treatment of epilepsy and other serious conditions. The list includes Virginia, where lawmakers earlier this year passed legislation allowing residents, including children, to use marijuana oils to treat seizures.

- D. The synopsis to S.B. 90 posits that age of the user should be immaterial:

These oils don't have enough "active ingredient" to get someone high. Therefore, there is no reason whatsoever not to allow its use for treatment of these conditions, no matter what the age of the person needing its help.

E. The text of S.B. 90 does not limit access to marijuana oils to minors. The definition of "usable marijuana" is amended to include "marijuana oil" and adults are eligible to receive "usable marijuana".

Second, it's unclear how much marijuana oil can be dispensed (to a child or adult). Section 7.2.8.3.1.2 limits dispensing to no more than 3 ounces of usable marijuana during a 14 day period. Three ounces of a liquid oil may be quite different than three ounces of a dried plant product. The Division may wish to assess whether the 3-oz. cap should apply to oils.

Third, the definition of "Responsible Party", second sentence, merits correction for grammar. There is a plural pronoun ("their") with a singular antecedent ("Party"). Consider substituting "Responsible Party's" for "their".

Fourth, an adult with a qualifying condition for whom a guardian has been appointed could participate in the program with the guardian serving as the "Responsible Party". However, §3.3.3 categorically presumes that anyone with a guardian will be a minor. Thus, only pediatric physicians are authorized to certify eligibility. The requirement that a pediatric physician certify the eligibility of an adult with a guardian should be corrected. Note that the reference to pediatric physicians in §3.3.3 may be redundant anyway given the definition of "Physician".

Fifth, §3.3.3.2 should be reviewed. Since there is a plural pronoun ("they") with a singular antecedent ("patient"), consider substituting "the patient has" for "they have". Moreover, the term "seizures" should be inserted after "nausea;". Compare S.B. No. 90, §4902A(3)b. There could be seizures without "painful and persistent muscle spasms".

Sixth, the grammar in §3.3.5 should be corrected. Substitute "Parties" for "Party's".

Seventh, the grammar in §5.3.8, first sentence, should be corrected. Consider the following substitute: "When a registered qualifying pediatric patient ~~passes their 18<sup>th</sup> birthday~~ attains 18 years of age, ~~they~~ the patient may...."

Eighth, §7.2.6 adopts more flexible standards for the maximum inventory of marijuana that can be maintained by a compassion center. This change is consistent with a recommendation in the attached article, M. Lally, "What's in Store for Delaware's First Medical Cannabis Dispensary" at p. 23:

In addition, Delaware law prohibits a registered compassion center from having more than 150 marijuana plants, irrespective of the stage of grow, or from possessing more than 1,500 ounces of usable marijuana, regardless of formulation. These restrictions may adversely impact the ability of registered dispensaries to produce enough medicine.

Adopting a more flexible standard is ostensibly a prudent amendment.

Ninth, instead of having a limit on the amount of medical marijuana determined by regulation (which is not individualized) it should be treated like other drugs and DPH should consider allowing physicians the ability to prescribe the amount and periodicity of medical marijuana administration.



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 Ernesto Lopez  
Mr. Mark Lally, First State Compassion Center  
Ms. Karyl Rattay, DHSS-DPH  
Ms. Debbie Gottschalk, DHSS  
Mr. Brian Hartman, Esq.  
Developmental Disabilities Council  
Governor's Advisory Council for Exceptional Citizens  
19reg91 dph emergency medical marijuana 8-26-15

ATTORNEY GENERAL'S OPINION - JANUARY 20, 1994

Letter to Pascale D. Forgione, Superintendent  
Delaware Department of Public Instruction

Re: Nurse in Attendance on Field Trips

"You have asked whether disabled children must be permitted to participate in school field trips and whether a nurse must be in attendance under any circumstances. You have also asked whether sick children must be permitted to participate in field trips and whether a nurse must be in attendance under any circumstances. The right of a disabled child to receive necessary medical services extends to non-scholastic activities as well as academic activities. If the disabled child requires a nurse to administer medications during the academic day, that same assistance should be afforded as an accommodation to that child while on a field trip. As to the second question, neither federal nor Delaware law specifically outlines the rights of children in school who are simply sick and generally sick children should be allowed on trips except under certain circumstances as discussed below.

As to disabled children, Section 504 of the Rehabilitation Act of 1973 as well as the Americans With Disabilities Act mandates that reasonable accommodations to the physical or mental limitations of any otherwise qualified disabled individual be made for that individual by a public entity, unless the entity can demonstrate the accommodation when imposed is an "undue hardship on the operation of its programs." 45 C.F.R. §84.12 (a).

The case law amply demonstrates that disabled children are entitled to receive necessary medical services while in school. Irving Independence School District v. Tatro, 468 U.S. 883 (1984). Further, other courts have held that schools must provide staff with the training to administer medical services and to assist the disabled child, if the need arises. Department of Education v. D., 531 F. Supp. 517 (D. Hawaii 1982); Department of Education, State of Hawaii v. Catherine D., 727 F. 2d 809 (9th Cir. 1983). Moreover, the right of a disabled child to receive necessary medical services extends to non-scholastic activity as well. 34 C.F.R. §104-37 (a) (2).

If disabled children can participate in field trips when provided with the same accommodations to which they are entitled at school, this accommodation must be offered to them. Quaker Valley (Pa) School District Complaint No. 03861077 Education for the Handicapped Law Report, 352:235 (Supp. 186 February 13, 1987.) A reasonable accommodation includes providing a nurse on school trips and other school outings. 45 C.F.R. §84-12 (a).

As to the second question regarding sick children, federal and state law does not deny access to academic and school related activities for sick children but for when they suffer from contagious illnesses such as diphtheria, measles, scarlet fever or smallpox. This raises the question as to whether sick children can be assisted with medication while in school and on field trips by someone other than a licensed nurse. It has been argued that the assistance of medication is the practice of nursing. We do not believe that necessarily to be so. Accordingly, a parent should be permitted to designate a care provider to assist her/his sick child. A parent can also authorize a sick child to care for themselves.

The mere assistance in taking medications is not the practice of nursing under 24 Del. C. Ch. 19. Twenty-four Del. C. §1902 (b) (6) states that a registered nurse execute regimens which include the dispensing and administration of medications. Twenty-four Del. C. §1902 (f) defines the administration of medication as a entire "process" whereby a nurse verifies the prescription drug order, removes the dose from a previously dispensed, properly labeled container, assesses the patient's status to assure it is given as prescribed to the proper patient and that no known contraindications to the drug or the dosage exists; gives a dose to the patient; then records the time and dose given. Further, under this statute the nurse would check the patient following the administration of the medication for possible side effects. *Id.*

If the parent of a sick child consents to that child self-administering medication or designates someone to assist with medications, that child should be allowed to participate in school field trips and a nurse need not be provided as there is no mandate under either federal or state law to accommodate a sick child. However, a parent cannot designate a care giver to act in such a way that the care giver is administering medicine as described above. Parents can consent to a care giver assisting with medications.

"Assistance with medications" is defined in the nursing statute as follows:

(g) "Assistance with medications" means the designated care provider assist the patient in the self-administration of a drug, provided that the medication is in the original container, with proper label and direction. The designated care provider must hold the container for the patient, assist patient in taking the medication." 24 Del. C. §1902.

This statute does not include the assistance with medication as a practice to be performed only by nurses.

To conclude, if a child is disabled, the same accommodation afforded in an academic setting must be available on field trips as the child has a right under federal law to participate in non-academic and extracurricular activities. If that accommodation is a nurse, then the nurse must be in attendance on a field trip.

A nurse need not accompany sick children on field trips as parents can consent to self-administration of medication or appoint a designated care giver if necessary. However, the designated care giver must not take up the activities which would be considered administration of medication under the Nursing Act as described above.

Malcolm S. Cobin  
Assistant State Solicitor

Loretta G. LeBar  
Deputy Attorney General

Approved: Michael F. Foster  
State Solicitor

Your Search...



Phone Numbers

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Help

Email

**Delaware General Assembly**

[Back](#)

**146th General Assembly**

**Senate Bill # 257**

- Home
- Bill Tracking
- Senate
  - Agenda
  - Ready List
  - Meeting Notices
  - Nominations
  - Roll Call
- House
  - Agenda
  - Ready List
  - Meeting Notices
  - Journal
  - Roll Call
- All Legislation
- Current Day's Action
- Recent Legislation
- Signed Legislation
- Calendar
- Reports:
  - By Sponsor
  - By Status
  - By Date Introduced
  - By Date Signed
  - Activity Report
  - Agenda Report
- Archives
- Contact Info
- House
  - Joint Committees
  - Legislative Divisions
  - Legislative Info
  - Meeting Schedules
  - Online Publications
  - Press Releases
  - Regulations
  - Schedule
  - Senate
  - Virtual Tour
  - Who's my Legislator

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**Introduced on :** 06/14/2012

**Long Title:** AN ACT TO AMEND TITLE 24 OF THE DELAWARE CODE RELATING TO ASSISTANCE WITH MEDICATIONS.

**Synopsis:** This Act expands the ability of persons to assist in the administration of medications to students by including coaches or persons hired or contracted by schools serving students in kindergarten through grade 12. The Act also provides for the assistance of medication during approved school activities outside the traditional school day and off-campus activities.

**Current Status:** Signed On 07/18/2012

**Volume Chapter:** 78:340

**Date Governor acted:** 07/18/2012

**Full text of Legislation: (in HTML format)** [Legis.html](#)      [Email this Bill to a friend](#)

**Full text of Legislation: (in MS Word format)** [Legis.Docx](#) (Microsoft Word is required to view this document.)

**Fiscal Notes/Fee Impact:** Not Required

**Committee Reports:** Senate Committee report 06/21/12 F=0 M=5 U=0---->

**Voting Reports:** Senate vote: ( ) Passed 6/27/2012 4:42:23 PM---->  
  
House vote: ( ) Passed 6/30/2012 11:54:20 PM---->

**Actions History:**

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Jul 18, 2012 - Signed by Governor  
 Jun 30, 2012 - Passed by House of Representatives. Votes: Passed 40 YES 0 NO 1 NOT VOTING 0 ABSENT 0 VACANT  
 Jun 30, 2012 - Necessary rules are suspended in House  
 Jun 28, 2012 - Introduced and Assigned to Health & Human Development Committee in House  
 Jun 27, 2012 - Passed by Senate. Votes: Passed 21 YES 0 NO 0 NOT VOTING 0 ABSENT 0 VACANT  
 Jun 21, 2012 - Reported Out of Committee (HEALTH & SOCIAL SERVICES) in Senate with 5 On Its Merits



SPONSOR: Sen. Hall-Long & Rep. Walker  
Sens. Blevins, Ennis, Henry, Katz, Simpson, Sokola &  
Sorenson;  
Reps. Barbieri, Briggs King, Carson, Jaques, Q. Johnson,  
Keeley & Ramone

DELAWARE STATE SENATE  
146th GENERAL ASSEMBLY

SENATE BILL NO. 257

AN ACT TO AMEND TITLE 24 OF THE DELAWARE CODE RELATING TO ASSISTANCE WITH  
MEDICATIONS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

1 Section 1. Amend §1921(a)(17), Title 24, Delaware Code, by making insertions as shown by underlining as  
2 follows:

3 (17) Educators, coaches, or persons hired or contracted by schools serving students in kindergarten through grade  
4 12 who assist students with medications that are self-administered during school field trips and approved school activities  
5 outside the traditional school day or off-campus that have completed a Board of Nursing approved training course  
6 developed by the Delaware Department of Education;

7

SYNOPSIS

This Act expands the ability of persons to assist in the administration of medications to students by including coaches or persons hired or contracted by schools serving students in kindergarten through grade 12. The Act also provides for the assistance of medication during approved school activities outside the traditional school day and off-campus activities.

Author: Senator Hall-Long

# PROPOSED REGULATIONS

to enter such information on an ongoing basis into an electronic statewide information system. The report Department shall reflect the district new teacher hiring activity from the "estimated unit count" as that term is defined pursuant to 14 Del.C. §1704 until November 15th of that same calendar year review and provide information on educator hiring practices and needs in the annual Delaware Talent Practices Report, to be provided no later than March 31<sup>st</sup> of the following year.

## OFFICE OF THE SECRETARY

Statutory Authority: 14 Delaware Code, Section 122(b) (14 Del.C. §122(b))  
14 DE Admin. Code 817

### PUBLIC NOTICE

#### Education Impact Analysis Pursuant To 14 Del.C. Section 122(d)

#### 817 Medications and Treatments

#### A. Type of Regulatory Action Required

Amendment to Existing Regulation

#### B. Synopsis of Subject Matter of the Regulation

The Acting Secretary of Education intends to amend 14 DE Admin. Code 817 Medications and Treatments. This regulation is amended to clarify assistance with self-administration of medications at unique approved school activities, such as extended field trips and to update a citation to the Delaware Code.

Persons wishing to present their views regarding this matter may do so in writing by the close of business on or before December 7, 2015 to Tina Shockley, Education Associate, Department of Education, Regulatory Review, at 401 Federal Street, Suite 2, Dover, Delaware 19901. A copy of this regulation may be viewed online at the Register of Regulation's website, [http://regulations.delaware.gov/services/current\\_issue.shtml](http://regulations.delaware.gov/services/current_issue.shtml), or obtained at the Department of Education, Finance Office located at the address listed above.

#### C. Impact Criteria

1. Will the amended regulation help improve student achievement as measured against state achievement standards? The amended regulation is related to medications and treatments and is not specifically related to improving student achievement as measured against state achievement standards.

2. Will the amended regulation help ensure that all students receive an equitable education? The amended regulation is intended to continue to help ensure all students receive an equitable education.

3. Will the amended regulation help to ensure that all students' health and safety are adequately protected? The amendments address students' health and safety in relation to assistance with self-administration of medications.

4. Will the amended regulation help to ensure that all students' legal rights are respected? The amended regulation continues to ensure that all student's legal rights are respected.

5. Will the amended regulation preserve the necessary authority and flexibility of decision making at the local board and school level? The amended regulations does not change the decision making at the local board and school level.

6. Will the amended regulation place unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels? The amended regulation does not place any unnecessary reporting or administrative requirements on decision makers.

7. Will the decision making authority and accountability for addressing the subject to be regulated be placed in the same entity? The decision making authority and accountability for addressing the subject to be regulated does not change because of the amendment.

8. Will the amended regulation be consistent with and not an impediment to the implementation of other state educational policies, in particular to state educational policies addressing achievement in the core academic

subjects of mathematics, science, language arts and social studies? The amendment is consistent with and not an impediment to the implementation of other state educational policies.

9. Is there a less burdensome method for addressing the purpose of the regulation? There is not a less burdensome method for addressing the purpose of the regulation.

10. What is the cost to the State and to the local school boards of compliance with the regulation? There is no cost to local schools boards for compliance with this amended regulation.

**817 Medications and Treatments**  
*(Break in Continuity of Sections)*

**2.0 Definitions**

The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly states otherwise:

*(Break in Continuity Within Section)*

**"Controlled Medication"** means those prescribed drugs regulated by Federal (CSA Controlled Substance Act of 1970) and/or State Controlled (dangerous) Substances Act.

*(Break in Continuity of Sections)*

**6.0 Assistance With Self-Administration of Medications at Approved School Activities**

6.1 Educators and Other School Employees who are Trained Assistants for Self-Administration are authorized by 24 **Del.C.** §1921(a)(173) to assist a student with self-administration of Medications at an Approved School Activity for students in kindergarten through Grade 12. The Trained Assistant for Self-Administration is subject to the following provisions:

6.1.1 Assistance with Self-Administration of Medication shall not be provided without the prior written request or consent of a parent, guardian or Relative Caregiver, or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a). Said written request or consent shall contain clear instructions including: the student's name; the name of the medication; the dose; the time(s) and date(s) of administration; and the method of administration. At least one copy of said written request or consent shall be in the possession of the person assisting a student with medication on a Field Trip or Approved School Activity outside of the traditional School day or off-campus.

*(Break in Continuity Within Section)*

6.1.2 In order to be qualified to provide Assistance with Self-Administration of Medications, each such person shall complete a Board of Nursing approved training course developed by the Delaware Department of Education, pursuant to 24 **Del.C.** §1921(a)(173). Training shall be renewed minimally every five years. No person shall provide Assistance with Self-Administration of Medications without documented acknowledgment to the Department of Education that he/she has completed the course and that he/she understands the same, and will abide by the safe practices and procedures set forth therein. A School Nurse shall:

*(Break in Continuity Within Section)*

6.2 District and charter school boards may develop policies for unique Approved School Activities for which the specified process is unable to be implemented.

\*Please Note: As the rest of the sections were not amended, they are not being published. A copy of the regulation is available at:

817 Medications and Treatments

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The Supreme Court of the United States  
526 U.S. 66 (1999)

[Print this page](#)

**CEDAR RAPIDS COMMUNITY SCHOOL DISTRICT**

v.

**GARRET F., a minor, by his mother and next friend, CHARLENE F.**

Certiorari to the United States Court of Appeals for the Eighth Circuit

No. 96-1793.

Argued November 4, 1998

Decided March 3, 1999

---

*Stevens, J.*, delivered the opinion of the Court, in which *Rehnquist, C. J.*, and *O'Connor, Scalia, Souter, Ginsburg, and Breyer, JJ.*, joined. *Thomas, J.*, filed a dissenting opinion, in which *Kennedy, J.*, joined.

**On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit**

*Justice Stevens* delivered the opinion of the Court.

The Individuals with Disabilities Education Act (IDEA), 84 Stat. 175, as amended, was enacted, in part, "to assure that all children with disabilities have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs." 20 U. S. C. §1400(c). Consistent with this purpose, the IDEA authorizes federal financial assistance to States that agree to provide disabled children with special education and "related services." See §§1401(a)(18), 1412(1). The question presented in this case is whether the definition of "related services" in §1401(a)(17)<sup>1</sup> requires a public school district in a participating State to provide a ventilator-dependent student with certain nursing services during school hours.

**I**

Respondent Garret F. is a friendly, creative, and intelligent young man. When Garret was four years old, his spinal column was severed in a motorcycle accident. Though paralyzed from the neck down, his mental capacities were unaffected. He is able to speak, to control his motorized wheelchair through use of a puff and suck straw, and to operate a computer with a device that responds to head movements. Garret is currently a student in the Cedar Rapids Community School District (District), he attends regular classes in a typical school program, and his academic performance has been a success. Garret is, however, ventilator dependent,<sup>2</sup> and therefore requires a responsible individual nearby to attend to certain physical needs while he is in school.<sup>3</sup>



During Garret's early years at school his family provided for his physical care during the school day. When he was in kindergarten, his 18-year-old aunt attended him; in the next four years, his family used settlement proceeds they received after the accident, their insurance, and other resources to employ a licensed practical nurse. In 1993, Garret's mother requested the District to accept financial responsibility for the health care services that Garret requires during the school day. The District denied the request, believing that it was not legally obligated to provide continuous one-on-one nursing services.

Relying on both the IDEA and Iowa law, Garret's mother requested a hearing before the Iowa Department of Education. An Administrative Law Judge (ALJ) received extensive evidence concerning Garret's special needs, the District's treatment of other disabled students, and the assistance provided to other ventilator-dependent children in other parts of the country. In his 47-page report, the ALJ found that the District has about 17,500 students, of whom approximately 2,200 need some form of special education or special services. Although Garret is the only ventilator-dependent student in the District, most of the health care services that he needs are already provided for some other students. <sup>4</sup> "The primary difference between Garret's situation and that of other students is his dependency on his ventilator for life support." App. to Pet. for Cert. 28a. The ALJ noted that the parties disagreed over the training or licensure required for the care and supervision of such students, and that those providing such care in other parts of the country ranged from non-licensed personnel to registered nurses. However, the District did not contend that only a licensed physician could provide the services in question.

The ALJ explained that federal law requires that children with a variety of health impairments be provided with "special education and related services" when their disabilities adversely affect their academic performance, and that such children should be educated to the maximum extent appropriate with children who are not disabled. In addition, the ALJ explained that applicable federal regulations distinguish between "school health services," which are provided by a "qualified school nurse or other qualified person," and "medical services," which are provided by a licensed physician. See 34 CFR §§300.16(a), (b)(4), (b)(11) (1998). The District must provide the former, but need not provide the latter (except, of course, those "medical services" that are for diagnostic or evaluation purposes, §1401(a)(17)). According to the ALJ, the distinction in the regulations does not just depend on "the title of the person providing the service"; instead, the "medical services" exclusion is limited to services that are "in the special training, knowledge, and judgment of a physician to carry out." App. to Pet. for Cert. 51a. The ALJ thus concluded that the IDEA required the District to bear financial responsibility for all of the services in dispute, including continuous nursing services. <sup>5</sup>

The District challenged the ALJ's decision in Federal District Court, but that Court approved the ALJ's IDEA ruling and granted summary judgment against the District. *Id.*, at 9a, 15a. The Court of Appeals affirmed. 106 F. 3d 822 (CA8 1997). It noted that, as a recipient of federal funds under the IDEA, Iowa has a statutory duty to provide all disabled children a "free appropriate public education," which includes "related services." See *id.*, at 824. The Court of Appeals read our opinion in *Irving Independent School Dist. v. Tatro*, 468 U. S. 883 (1984), to provide a two-step analysis of the "related services" definition in §1401(a)(17) -- asking first, whether the requested services are included within the phrase "supportive services"; and second, whether the services are excluded as "medical services." 106 F. 3d, at 824-825. The Court of Appeals succinctly answered both questions in Garret's favor. The Court found the first step plainly satisfied, since Garret cannot attend school unless the requested services are available during the school day. *Id.*, at 825. As to the second step, the Court reasoned that *Tatro* "established a bright-line test: the services of a physician (other than for diagnostic and

evaluation purposes) are subject to the medical services exclusion, but services that can be provided in the school setting by a nurse or qualified layperson are not." *Ibid.*

In its petition for certiorari, the District challenged only the second step of the Court of Appeals' analysis. The District pointed out that some federal courts have not asked whether the requested health services must be delivered by a physician, but instead have applied a multi-factor test that considers, generally speaking, the nature and extent of the services at issue. See, e.g., *Neely v. Rutherford County School*, 68 F. 3d 965, 972-973 (CA6 1995), cert. denied, 517 U. S. 1134 (1996); *Detsel v. Board of Ed. of Auburn Enlarged City School Dist.*, 820 F. 2d 587, 588 (CA2) (*per curiam*), cert. denied, 484 U. S. 981 (1987). We granted the District's petition to resolve this conflict. 523 U. S. \_\_\_ (1998).

## II

The District contends that §1401(a)(17) does not require it to provide Garret with "continuous one-on-one nursing services" during the school day, even though Garret cannot remain in school without such care. Brief for Petitioner 10. However, the IDEA's definition of "related services," our decision in *Irving Independent School Dist. v. Tatro*, 468 U. S. 883 (1984), and the overall statutory scheme all support the decision of the Court of Appeals.

The text of the "related services" definition, see n. 1, *supra*, broadly encompasses those supportive services that "may be required to assist a child with a disability to benefit from special education." As we have already noted, the District does not challenge the Court of Appeals' conclusion that the in-school services at issue are within the covered category of "supportive services." As a general matter, services that enable a disabled child to remain in school during the day provide the student with "the meaningful access to education that Congress envisioned." *Tatro*, 468 U. S., at 891 ("Congress sought primarily to make public education available to handicapped children' and 'to make such access meaningful' " (quoting *Board of Ed. of Hendrick Hudson Central School Dist., Westchester Cty. v. Rowley*, 458 U. S. 176, 192 (1982))).

This general definition of "related services" is illuminated by a parenthetical phrase listing examples of particular services that are included within the statute's coverage. §1401(a)(17). "Medical services" are enumerated in this list, but such services are limited to those that are "for diagnostic and evaluation purposes." *Ibid.* The statute does not contain a more specific definition of the "medical services" that are excepted from the coverage of §1401(a)(17).

The scope of the "medical services" exclusion is not a matter of first impression in this Court. In *Tatro* we concluded that the Secretary of Education had reasonably determined that the term "medical services" referred only to services that must be performed by a physician, and not to school health services. 468 U. S., at 892-894. Accordingly, we held that a specific form of health care (clean intermittent catheterization) that is often, though not always, performed by a nurse is not an excluded medical service. We referenced the likely cost of the services and the competence of school staff as justifications for drawing a line between physician and other services, *ibid.*, but our endorsement of that line was unmistakable.<sup>6</sup> It is thus settled that the phrase "medical services" in §1401(a)(17) does not embrace all forms of care that might loosely be described as "medical" in other contexts, such as a claim for an income tax deduction. See 26 U. S. C. §213(d)(1) (1994 ed. and Supp. II) (defining "medical care").

The District does not ask us to define the term so broadly. Indeed, the District does not argue that any of the items of care that Garret needs, considered individually, could be excluded from the scope of

§1401(a)(17).<sup>7</sup> It could not make such an argument, considering that one of the services Garret needs (catheterization) was at issue in *Tatro*, and the others may be provided competently by a school nurse or other trained personnel. See App. to Pet. for Cert. 15a, 52a. As the ALJ concluded, most of the requested services are already provided by the District to other students, and the in-school care necessitated by Garret's ventilator dependency does not demand the training, knowledge, and judgment of a licensed physician. *Id.*, at 51a-52a. While more extensive, the in-school services Garret needs are no more "medical" than was the care sought in *Tatro*.

Instead, the District points to the combined and continuous character of the required care, and proposes a test under which the outcome in any particular case would "depend upon a series of factors, such as [1] whether the care is continuous or intermittent, [2] whether existing school health personnel can provide the service, [3] the cost of the service, and [4] the potential consequences if the service is not properly performed." Brief for Petitioner 11; see also *id.*, at 34-35.

The District's multi-factor test is not supported by any recognized source of legal authority. The proposed factors can be found in neither the text of the statute nor the regulations that we upheld in *Tatro*. Moreover, the District offers no explanation why these characteristics make one service any more "medical" than another. The continuous character of certain services associated with Garret's ventilator dependency has no apparent relationship to "medical" services, much less a relationship of equivalence. Continuous services may be more costly and may require additional school personnel, but they are not thereby more "medical." Whatever its imperfections, a rule that limits the medical services exemption to physician services is unquestionably a reasonable and generally workable interpretation of the statute. Absent an elaboration of the statutory terms plainly more convincing than that which we reviewed in *Tatro*, there is no good reason to depart from settled law.<sup>8</sup>

Finally, the District raises broader concerns about the financial burden that it must bear to provide the services that Garret needs to stay in school. The problem for the District in providing these services is not that its staff cannot be trained to deliver them; the problem, the District contends, is that the existing school health staff cannot meet all of their responsibilities and provide for Garret at the same time.<sup>9</sup>

Through its multi-factor test, the District seeks to establish a kind of undue-burden exemption primarily based on the cost of the requested services. The first two factors can be seen as examples of cost-based distinctions: intermittent care is often less expensive than continuous care, and the use of existing personnel is cheaper than hiring additional employees. The third factor—the cost of the service—would then encompass the first two. The relevance of the fourth factor is likewise related to cost because extra care may be necessary if potential consequences are especially serious.

The District may have legitimate financial concerns, but our role in this dispute is to interpret existing law. Defining "related services" in a manner that accommodates the cost concerns Congress may have had, cf. *Tatro*, 468 U. S., at 892, is altogether different from using cost itself as the definition. Given that §1401(a)(17) does not employ cost in its definition of "related services" or excluded "medical services," accepting the District's cost-based standard as the sole test for determining the scope of the provision would require us to engage in judicial lawmaking without any guidance from Congress. It would also create some tension with the purposes of the IDEA. The statute may not require public schools to maximize the potential of disabled students commensurate with the opportunities provided to other children, see *Rowley*, 458 U. S., at 200; and the potential financial burdens imposed on participating States may be relevant to arriving at a sensible construction of the IDEA, see *Tatro*, 468 U. S., at 892. But Congress intended "to open the door of public education" to all qualified children

and "require[d] participating States to educate handicapped children with non-handicapped children whenever possible." *Rowley*, 458 U. S., at 192, 202; see *id.*, at 179-181; see also *Honig v. Doe*, 484 U. S. 305, 310-311, 324 (1988); §§1412(1), (2)(c), (5)(B).<sup>10</sup>

This case is about whether meaningful access to the public schools will be assured, not the level of education that a school must finance once access is attained. It is undisputed that the services at issue must be provided if Garret is to remain in school.

Under the statute, our precedent, and the purposes of the IDEA, the District must fund such "related services" in order to help guarantee that students like Garret are integrated into the public schools.

The judgment of the Court of Appeals is accordingly *Affirmed*.

### ***Dissent:***

*Justice Thomas*, with whom *Justice Kennedy* joins, dissenting.

The majority, relying heavily on our decision in *Irving Independent School Dist. v. Tatro*, 468 U. S. 883 (1984), concludes that the Individuals with Disabilities Education Act (IDEA), 20 U. S. C. §1400 et seq., requires a public school district to fund continuous, one-on-one nursing care for disabled children. Because *Tatro* cannot be squared with the text of IDEA, the Court should not adhere to it in this case. Even assuming that *Tatro* was correct in the first instance, the majority's extension of it is unwarranted and ignores the constitutionally mandated rules of construction applicable to legislation enacted pursuant to Congress' spending power.

### **I**

As the majority recounts, *ante*, at 1, IDEA authorizes the provision of federal financial assistance to States that agree to provide, *inter alia*, "special education and related services" for disabled children. §1401(a)(18). In *Tatro*, *supra*, we held that this provision of IDEA required a school district to provide clean intermittent catheterization to a disabled child several times a day. In so holding, we relied on Department of Education regulations, which we concluded had reasonably interpreted IDEA's definition of "related services"<sup>1</sup> to require school districts in participating States to provide "school nursing services" (of which we assumed catheterization was a subcategory) but not "services of a physician." *Id.*, at 892-893. This holding is contrary to the plain text of IDEA and its reliance on the Department of Education's regulations was misplaced.

### **A**

Before we consider whether deference to an agency regulation is appropriate, "we first ask whether Congress has 'directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.'" *National Credit Union Admin. v. First Nat. Bank & Trust Co.*, 522 U. S. 479, 499-500 (1998) (quoting *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837, 842-843 (1984)).

Unfortunately, the Court in *Tatro* failed to consider this necessary antecedent question before turning to the Department of Education's regulations implementing IDEA's related services provision. The Court instead began "with the regulations of the Department of Education, which," it said, "are

entitled to deference." *Tatro*, *supra*, at 891-892. The Court need not have looked beyond the text of IDEA, which expressly indicates that school districts are not required to provide medical services, except for diagnostic and evaluation purposes. 20 U. S. C. §1401(a)(17). The majority asserts that *Tatro* precludes reading the term "medical services" to include "all forms of care that might loosely be described as 'medical.'" *Ante*, at 8. The majority does not explain, however, why "services" that are "medical" in nature are not "medical services." Not only is the definition that the majority rejects consistent with other uses of the term in federal law,<sup>2</sup> it also avoids the anomalous result of holding that the services at issue in *Tatro* (as well as in this case), while not "medical services," would nonetheless qualify as medical care for federal income tax purposes. *Ante*, at 8.

The primary problem with *Tatro*, and the majority's reliance on it today, is that the Court focused on the provider of the services rather than the services themselves. We do not typically think that automotive services are limited to those provided by a mechanic, for example. Rather, anything done to repair or service a car, no matter who does the work, is thought to fall into that category. Similarly, the term "food service" is not generally thought to be limited to work performed by a chef. The term "medical" similarly does not support *Tatro*'s provider-specific approach, but encompasses services that are "of, relating to, or concerned with physicians or the practice of medicine." See Webster's Third New International Dictionary 1402 (1986) (emphasis added); see also *id.*, at 1551 (defining "nurse" as "a person skilled in caring for and waiting on the infirm, the injured, or the sick; *specif*: one esp. trained to carry out such duties under the supervision of a physician").

IDEA's structure and purpose reinforce this textual interpretation. Congress enacted IDEA to increase the *educational* opportunities available to disabled children, not to provide medical care for them. See 20 U. S. C. §1400(c) ("It is the purpose of this chapter to assure that all children with disabilities have . . . a free appropriate public education"); see also §1412 ("In order to qualify for assistance . . . a State shall demonstrate . . . [that it] has in effect a policy that assures all children with disabilities the right to a free appropriate public education"); *Board of Ed. of Hendrick Hudson Central School Dist., Westchester Cty. v. Rowley*, 458 U. S. 176, 179 (1982) ("The Act represents an ambitious federal effort to promote the education of handicapped children"). As such, where Congress decided to require a supportive service—including speech pathology, occupational therapy, and audiology—that appears "medical" in nature, it took care to do so explicitly. See §1401(a)(17). Congress specified these services precisely because it recognized that they would otherwise fall under the broad "medical services" exclusion. Indeed, when it crafted the definition of related services, Congress could have, but chose not to, include "nursing services" in this list.

## B

*Tatro* was wrongly decided even if the phrase "medical services" was subject to multiple constructions, and therefore, deference to any reasonable Department of Education regulation was appropriate. The Department of Education has never promulgated regulations defining the scope of IDEA's "medical services" exclusion. One year before *Tatro* was decided, the Secretary of Education issued proposed regulations that defined excluded medical services as "services relating to the practice of medicine." 47 Fed. Reg. 33838 (1982). These regulations, which represent the Department's only attempt to define the disputed term, were never adopted. Instead, "[t]he regulations actually define only those 'medical services' that *are* owed to handicapped children," *Tatro*, 468 U. S., at 892, n. 10) (emphasis in original), not those that *are not*. Now, as when *Tatro* was decided, the regulations require districts to provide services performed " 'by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special

education and related services.' " *Ibid.* (quoting 34 CFR §300.13(b)(4) (1983), recodified and amended as 34 CFR §300.16(b)(4) (1998).

Extrapolating from this regulation, the *Tatro* Court presumed that this meant "that 'medical services' not owed under the statute are those 'services by a licensed physician' that serve other purposes." *Tatro*, *supra*, at 892, n. 10 (emphasis deleted). The Court, therefore, did not defer to the regulation itself, but rather relied on an inference drawn from it to speculate about how a regulation might read if the Department of Education promulgated one. Deference in those circumstances is impermissible. We cannot defer to a regulation that does not exist.<sup>3</sup>

## II

Assuming that *Tatro* was correctly decided in the first instance, it does not control the outcome of this case. Because IDEA was enacted pursuant to Congress' spending power, *Rowley*, *supra*, at 190, n. 11, our analysis of the statute in this case is governed by special rules of construction. We have repeatedly emphasized that, when Congress places conditions on the receipt of federal funds, "it must do so unambiguously." *Pennhurst State School and Hospital v. Halderman*, 451 U. S. 1, 17 (1981). See also *Rowley*, *supra*, at 190, n. 11; *South Dakota v. Dole*, 483 U. S. 203, 207 (1987); *New York v. United States*, 505 U. S. 144, 158 (1992).

This is because a law that "condition[s] an offer of federal funding on a promise by the recipient ... amounts essentially to a contract between the Government and the recipient of funds." *Gebser v. Lago Vista Independent School Dist.*, 524 U. S. 274, 276 (1998). As such, "[t]he legitimacy of Congress' power to legislate under the spending power . . . rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it." *Pennhurst*, *supra*, at 17 (citations omitted). It follows that we must interpret Spending Clause legislation narrowly, in order to avoid saddling the States with obligations that they did not anticipate.

The majority's approach in this case turns this Spending Clause presumption on its head. We have held that, in enacting IDEA, Congress wished to require "States to educate handicapped children with nonhandicapped children whenever possible," *Rowley*, 458 U. S., at 202. Congress, however, also took steps to limit the fiscal burdens that States must bear in attempting to achieve this laudable goal. These steps include requiring States to provide an education that is only "appropriate" rather than requiring them to maximize the potential of disabled students, see 20 U. S. C. §1400(c) *Rowley*, *supra*, at 200, recognizing that integration into the public school environment is not always possible, see §1412(5), and clarifying that, with a few exceptions, public schools need not provide "medical services" for disabled students, §§1401(a)(17) and (18).

For this reason, we have previously recognized that Congress did not intend to "impos[e] upon the States a burden of unspecified proportions and weight" in enacting IDEA. *Rowley*, *supra*, at 176, n. 11. These federalism concerns require us to interpret IDEA's related services provision, consistent with *Tatro*, as follows: Department of Education regulations require districts to provide disabled children with health-related services that school nurses can perform as part of their normal duties. This reading of *Tatro*, although less broad than the majority's, is equally plausible and certainly more consistent with our obligation to interpret Spending Clause legislation narrowly. Before concluding that the district was required to provide clean intermittent catheterization for Amber Tatro, we observed that school nurses in the district were authorized to perform services that were "difficult to distinguish from the provision of [clean intermittent catheterization] to the handicapped." *Tatro*, 468 U. S., at 893. We concluded that "[i]t would be strange indeed if Congress, in attempting to extend

special services to handicapped children, were unwilling to guarantee them services of a kind that are routinely provided to the nonhandicapped." *Id.*, at 893-894.

Unlike clean intermittent catheterization, however, a school nurse cannot provide the services that respondent requires, see *ante*, at 3, n. 3, and continue to perform her normal duties. To the contrary, because respondent requires continuous, one-on-one care throughout the entire school day, all agree that the district must hire an additional employee to attend solely to respondent. This will cost a minimum of \$18,000 per year. Although the majority recognizes this fact, it nonetheless concludes that the "more extensive" nature of the services that respondent needs is irrelevant to the question whether those services fall under the medical services exclusion. *Ante*, at 9. This approach disregards the constitutionally mandated principles of construction applicable to Spending Clause legislation and blindsides unwary States with fiscal obligations that they could not have anticipated.

\* \* \*

For the foregoing reasons, I respectfully dissent.

## FOOTNOTES

[1] "The term 'related services' means transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, social work services, counseling services, including rehabilitation counseling, and medical services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a child with a disability to benefit from special education, and includes the early identification and assessment of disabling conditions in children." 20 U. S. C. §1401(a)(17).

Originally, the statute was enacted without a definition of "related services." See Education of the Handicapped Act, 84 Stat. 175. In 1975, Congress added the definition at issue in this case. Education for All Handicapped Children Act of 1975, §4(a)(4), 89 Stat. 775. Aside from nonsubstantive changes and added examples of included services, see, e.g., Individuals with Disabilities Education Act Amendments of 1997, §101, 111 Stat. 45; Individuals with Disabilities Education Act Amendments of 1991, §25(a)(1)(B), 105 Stat. 605; Education of the Handicapped Act Amendments of 1990, §101(c), 104 Stat. 1103, the relevant language in §1401(a)(17) has not been amended since 1975. All references to the IDEA herein are to the 1994 version as codified in Title 20 of the United States Code—the version of the statute in effect when this dispute arose.

[2] In his report in this case, the Administrative Law Judge explained that "[b]eing ventilator dependent means that [Garret] breathes only with external aids, usually an electric ventilator, and occasionally by someone else's manual pumping of an air bag attached to his tracheotomy tube when the ventilator is being maintained. This later procedure is called ambu bagging." App. to Pet. for Cert. 19a.

[3] "He needs assistance with urinary bladder catheterization once a day, the suctioning of his tracheotomy tube as needed, but at least once every six hours, with food and drink at lunchtime, in getting into a reclining position for five minutes of each hour, and ambu bagging occasionally as needed when the ventilator is checked for proper functioning. He also needs assistance from someone familiar with his ventilator in the event there is a malfunction or electrical problem, and someone who can perform emergency procedures in the event he experiences autonomic hyperreflexia. Autonomic

hyperreflexia is an uncontrolled visceral reaction to anxiety or a full bladder. Blood pressure increases, heart rate increases, and flushing and sweating may occur.

Garret has not experienced autonomic hyperreflexia frequently in recent years, and it has usually been alleviated by catheterization. He has not ever experienced autonomic hyperreflexia at school. Garret is capable of communicating his needs orally or in another fashion so long as he has not been rendered unable to do so by an extended lack of oxygen." *Id.*, at 20a.

[4] "Included are such services as care for students who need urinary catheterization, food and drink, oxygen supplement positioning, and suctioning." *Id.*, at 28a; see also *id.*, at 53a.

[5] In addition, the ALJ's opinion contains a thorough discussion of "other tests and criteria" pressed by the District, *id.*, at 52a, including the burden on the District and the cost of providing assistance to Garret. Although the ALJ found no legal authority for establishing a cost-based test for determining what related services are required by the statute, he went on to reject the District's arguments on the merits. See *id.*, at 42a-53a. We do not reach the issue here, but the ALJ also found that Garret's in-school needs must be met by the District under an Iowa statute as well as the IDEA. *Id.*, at 54a-55a.

[6] "The regulations define 'related services' for handicapped children to include 'school health services,' 34 CFR §300.13(a) (1983), which are defined in turn as 'services provided by a qualified school nurse or other qualified person,' §300.13(b)(10). 'Medical services' are defined as 'services provided by a licensed physician.' §300.13(b)(4). Thus, the Secretary has [reasonably] determined that the services of a school nurse otherwise qualifying as a 'related service' are not subject to exclusion as a 'medical service,' but that the services of a physician are excludable as such.

"... By limiting the 'medical services' exclusion to the services of a physician or hospital, both far more expensive, the Secretary has given a permissible construction to the provision." 468 U. S., at 892-893 (emphasis added) (footnote omitted); see also *id.*, at 894 ("[T]he regulations state that school nursing services must be provided only if they can be performed by a nurse or other qualified person, not if they must be performed by a physician").

Based on certain policy letters issued by the Department of Education, it seems that the Secretary's post-*Tatro* view of the statute has not been entirely clear. E.g., App. to Pet. for Cert. 64a. We may assume that the Secretary has authority under the IDEA to adopt regulations that define the "medical services" exclusion by more explicitly taking into account the nature and extent of the requested services; and the Secretary surely has the authority to enumerate the services that are, and are not, fairly included within the scope of §1407(a)(17). But the Secretary has done neither; and, in this Court, she advocates affirming the judgment of the Court of Appeals. Brief for United States as Amicus Curiae; see also *Auer v. Robbins*, 519 U. S. 452, 462 (1997) (an agency's views as amicus curiae may be entitled to deference). We obviously have no authority to rewrite the regulations, and we see no sufficient reason to revise *Tatro*, either.

[7] See Tr. of Oral Arg. 4-5, 12.

[8] At oral argument, the District suggested that we first consider the nature of the requested service (either "medical" or not); then, if the service is "medical," apply the multi-factor test to determine whether the service is an excluded physician service or an included school nursing service under the Secretary of Education's regulations. See Tr. of Oral Arg. 7, 13-14. Not only does this approach provide no additional guidance for identifying "medical" services, it is also disconnected from both



the statutory text and the regulations we upheld in *Irving Independent School Dist. v. Tatro*, 468 U. S. 883 (1984).

"Medical" services are generally excluded from the statute, and the regulations elaborate on that statutory term. No authority cited by the District requires an additional inquiry if the requested service is both "related" and non-"medical." Even if §1401(a)(17) demanded an additional step, the factors proposed by the District are hardly more useful in identifying "nursing" services than they are in identifying "medical" services; and the District cannot limit educational access simply by pointing to the limitations of existing staff. As we noted in *Tatro*, the IDEA requires schools to hire specially trained personnel to meet disabled student needs. *Id.*, at 893.

[9] See Tr. of Oral Arg. 4-5, 13; Brief for Petitioner 6-7, 9. The District, however, will not necessarily need to hire an additional employee to meet Garret's needs. The District already employs a one-on-one teacher associate (TA) who assists Garret during the school day. See App. to Pet. for Cert. 26a-27a. At one time, Garret's TA was a licensed practical nurse (LPN). In light of the state Board of Nursing's recent ruling that the District's registered nurses may decide to delegate Garret's care to an LPN, see Brief for United States as Amicus Curiae 9-10 (filed Apr. 22, 1998), the dissent's future-cost estimate is speculative. See App. to Pet. for Cert. 28a, 58a-60a (if the District could assign Garret's care to a TA who is also an LPN, there would be "a minimum of additional expense").

[10] The dissent's approach, which seems to be even broader than the District's, is unconvincing. The dissent's rejection of our unanimous decision in *Tatro* comes 15 years too late, see *Patterson v. McLean Credit Union*, 491 U. S. 164, 172-173 (1989) (*stare decisis* has "special force" in statutory interpretation), and it offers nothing constructive in its place. Aside from rejecting a "provider-specific approach," the dissent cites unrelated statutes and offers a circular definition of "medical services." Post, at 3-4 (" 'services' that are 'medical' in 'nature' "). Moreover, the dissent's approach apparently would exclude most ordinary school nursing services of the kind routinely provided to nondisabled children; that anomalous result is not easily attributable to congressional intent. See *Tatro*, 468 U. S., at 893.

In a later discussion the dissent does offer a specific proposal: that we now interpret (or rewrite) the Secretary's regulations so that school districts need only provide disabled children with "health-related services that school nurses can perform as part of their normal duties." Post, at 7. The District does not dispute that its nurses "can perform" the requested services, so the dissent's objection is that District nurses would not be performing their "normal duties" if they met Garret's needs. That is, the District would need an "additional employee." Post, at 8. This proposal is functionally similar to a proposed regulation—ultimately withdrawn—that would have replaced the "school health services" provision. See 47 Fed. Reg. 33838, 33854 (1982) (the statute and regulations may not be read to affect legal obligations to make available to handicapped children services, including school health services, made available to nonhandicapped children). The dissent's suggestion is unacceptable for several reasons. Most important, such revisions of the regulations are better left to the Secretary, and an additional staffing need is generally not a sufficient objection to the requirements of §1401(a)(17). See n. 8, *supra*.

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#### FOOTNOTES - Dissent

[1] The Act currently defines "related services" as "transportation and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services,

physical and occupational therapy, recreation, including therapeutic recreation, social work services, counseling services, including rehabilitation counseling, and medical services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a child with a disability to benefit from special education . . . ." 20 U. S. C. §1401(a)(17) (emphasis added).

[2] See, e.g., 38 U. S. C. §1701(6) ("The term 'medical services' includes, in addition to medical examination, treatment and rehabilitative services ... surgical services, dental services . . . optometric and podiatric services, . . . preventive health services, . . . [and] such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment"); §101(28) ("The term 'nursing home care' means the accommodation of convalescents . . . who require nursing care and related medical services"); 26 U. S. C. §213(d)(1) ("The term 'medical care' means amounts paid-- . . . for the diagnosis, cure, mitigation, treatment, or prevention of disease").

[3] Nor do I think that it is appropriate to defer to the Department of Education's litigating position in this case. The agency has had ample opportunity to address this problem but has failed to do so in a formal regulation. Instead, it has maintained conflicting positions about whether the services at issue in this case are required by IDEA. See ante, at 7-8, n. 6. Under these circumstances, we should not assume that the litigating position reflects the "agency's fair and considered judgment." *Auer v. Robbins*, 519 U. S. 452, 462 (1997).

To Top

**Note:** This and other decisions in key special education cases from the U. S. Supreme Court are included in Wrightslaw: Special Education Law, 2nd Edition.

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## DELAWARE ADMINISTRATIVE CODE STYLE MANUAL (EXCERPT)

### 4.3 Definitions (See Figure 4.1)

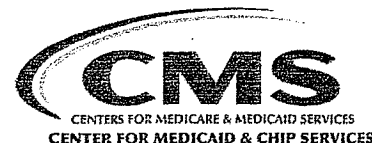
It is recommended that definitions of terms be included in each regulation. Definitions provide clarification of terms used within a regulation, save space in the body of the regulation, and allow the regulation writer to control the meaning of a word. Define a term only when the meaning of a word is important and it is used more than once in the regulation. Do not define ordinary words that are used in their dictionary context.

Regulatory information should not be included in the definition.

#### **Example of a Definition that is Too Substantive:**

**"Lockup facility"** means a secure adult detention facility used to confine prisoners waiting to appear in court and sentenced prisoners for not more than 90 days. In addition to the cell, a lockup facility must include space for moderate exercise and activity, such as weight lifting, ping-pong, table games, reading, television, and cards.

This definition should end at "90 days."



**Center for Medicaid and CHIP Services**

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***CMCS Informational Bulletin***

**DATE:** November 28, 2012

**FROM:** Cindy Mann, Director  
Center for Medicaid and CHIP Services (CMCS)

**SUBJECT:** Inpatient Psychiatric Services for Individuals under age 21

This Informational Bulletin clarifies that states may structure coverage and payment for the benefit category of inpatient psychiatric hospital or facility services for individuals under age 21 (hereinafter referred to as inpatient psychiatric facility benefit) to ensure that children receiving this benefit obtain all services necessary to meet their medical, psychological, social, behavioral and developmental needs, as identified in a plan of care. This clarification is intended to describe flexibility currently available to states to ensure the provision of medically necessary Medicaid services to children in inpatient psychiatric facilities.

**Background**

Under section 1905(a) of the Social Security Act (the Act), there is a general prohibition on Medicaid payment for any services provided to any individual who is under age 65 and who is residing in an Institution for Mental Diseases (IMD) unless the payment is for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(a)(16) of the Act, as defined in section 1905(h) of the Act. Implementing regulations at 42 Code of Federal Regulation 440.160 and 441 Subpart D define these inpatient psychiatric hospital services as services furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility that meets certain requirements. These requirements include that the services must be provided under the direction of a physician, pursuant to a certification of need and plan of care developed by an interdisciplinary team of professionals, and must involve "active treatment" designed to achieve the child's discharge from inpatient status at the earliest possible time.

The Centers for Medicare and Medicaid Services (CMS) has historically prohibited states from claiming expenditures under the inpatient psychiatric facility benefit unless the expenditures were made to qualified providers of such services. This had the effect of denying coverage for other medically necessary Medicaid items and services, such as prescription drugs or practitioner services that were not included by the state as part of the rate paid to the facility for care. These items and services would be available under other benefit categories for individuals who did not reside in an IMD, such as the benefit for Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and states had separate payment methodologies for such items and services.

Recently, several Departmental Appeals Board decisions have clarified that other covered services can be furnished as part of the inpatient psychiatric facility benefit even when payment was made to an individual practitioner or supplier other than the inpatient psychiatric facility itself, when such services are furnished to a child residing in such a facility, authorized under the child's plan of care, and provided under an arrangement with the facility. In essence, the Departmental Appeals Board indicated that payment for such services does not need to be bundled into a single per diem rate for

the IMD facility, but could be authorized under the approved State plan to be paid directly to the treating practitioner. In light of these decisions, CMS is currently applying this flexibility in the approval of State Plan amendments, and seeks to clarify the ability that states have in covering and paying for a more robust benefit for children receiving the inpatient psychiatric facility benefit.

### **Services Provided under Arrangement**

The inpatient psychiatric facility benefit is defined in part to include a needs assessment and the development of a plan of care specific to meet each child's medical, psychological, social, behavioral and developmental needs. In some cases a psychiatric facility may wish to obtain services reflected in the plan of care under arrangement with qualified non-facility providers. Such services would be components of the inpatient psychiatric facility benefit when included in the child's inpatient psychiatric plan of care and furnished by a qualified provider that has entered into a contract with the inpatient psychiatric facility to furnish the services to its inpatients. To comply with the requirement that services be "provided by" a qualified psychiatric facility, the psychiatric facility must arrange for and oversee the provision of all services, must maintain all medical records of care furnished to the individual, and must ensure that all services are furnished under the direction of a physician. Services being furnished under arrangement do not need to be provided at the psychiatric facility itself if these conditions are met.

### **Payment for Services Provided under Arrangement**

States have a number of options in electing a methodology in their Medicaid State plans to pay for the inpatient psychiatric facility benefit. Traditionally, many states make a direct payment to the facility through either an all-inclusive per diem rate or a base per diem rate with add-on payments. Under this direct payment method, if the facility obtains services under arrangement with outside providers, the facility would be responsible for paying the providers of the arranged services.

An option that may be more flexible, and has been approved in State Plan amendments, is to directly reimburse individual practitioners or suppliers of arranged services using payment methodologies that are applicable when the services are otherwise available under the State plan. States electing this option would pay the same fees to such practitioners or suppliers as would otherwise be applicable when the services are furnished to Medicaid beneficiaries outside the inpatient psychiatric facility benefit. This option would allow states greater ability to capture potential efficiencies, and monitor the quality of care, through the use of existing delivery and billing processes. States electing to make separate payments under this option will need to assure there is no duplication of payment between the inpatient facility rate and the items paid for separately using existing State plan fees. It is important to note that while the state may directly reimburse individual providers, CMS will require expenditures for all services provided to individuals receiving services through the inpatient psychiatric facility benefit to be reported and claimed on the Mental Health Facility Services line item of the CMS 64 form, and not under the line item applicable to the furnished Medicaid service.

We are ready to work with states to provide assistance in implementing this benefit, and we look forward to our continuing collaboration. If you have questions, please contact Ms. Barbara Edwards, Director, Disabled and Elderly Health Programs Group, at 410-786-7089, or at [Barbara.Edwards@cms.hhs.gov](mailto:Barbara.Edwards@cms.hhs.gov).