



DISABILITIES LAW PROGRAM

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MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory Initiatives

Date: July 12, 2016

Consistent with the requests of the SCPD and GACEC, I am providing an analysis of four (4) regulatory initiatives. Given time constraints, the analyses should be considered preliminary and non-exhaustive.

1. DMMA Final Spousal Impoverishment Undue Hardship Reg. [20 DE Reg. 52 (7/1/16)]

The SCPD and GACEC commented on the proposed version of this regulation in May, 2016. DMMA responded through the attached June 2, 2016 memo which reproduces the SCPD's comments followed by DMMA's perspective. An identical memo was sent to the GACEC. DMMA is now adopting a final regulation with no changes prompted by the Councils' comments.

First, the Councils noted Delaware adopted its current spousal impoverishment standard of \$25,000 in 1993. The Councils recommended increasing the \$25,000 figure. DMMA declined the invitation based on the current formula which effectively sets the maximum resource limit at \$119,220.

Second, the Councils objected to an undue hardship standard which allows consideration of medical expenses only if the individual would die without the medical care. DMMA declined to amend the standard.

Since the regulation is final, and the Division responded to each of the Councils' comments, I recommend no further action.

2. DOE Final School Nurse Regulation [20 DE Reg. 49 (7/1/16)]

The SCPD and GACEC commented on the proposed version of this regulation in May, 2016. A copy of the SCPD's May 25 memo is attached for facilitated reference.

The Councils had only one (1) suggestion, i.e., modifying a reference to verification of nurse compliance with certain standards. The Professional Standards Board has now adopted a final regulation with no amendment. The Board shared only the following unenlightening rationale: "The Professional Standards Board considered the written comments and decided not to make any changes to the proposed regulation at this time." At 49.

Since the regulation is final, and the Board considered the Councils' comments, I recommend no further action.

3. DMMA Prop. Autism Disorder Services Regulation [20 DE Reg. 11 (7/1/16)]

The Division of Medicaid and Medical Assistance published an initial proposed autism disorder services regulation in April, 2016. The SCPD and GACEC submitted extensive commentary on that version. Instead of adopting a final regulation, the Division is now republishing a revised regulation which incorporates some amendments prompted by the comments of the Councils and other agencies. For facilitated reference, the Division shared the attached May 17, 2016 memo which reproduces the SCPD's comments followed by the Division's response.

First, the Councils questioned the adoption of an "under the age of 21" qualification standard since the standard does not appear in the EPSDT section of the State Plan. In response, DMMA characterizes the age limit as an EPSDT amendment to the State Plan although placed in the Preventive Services section of the Plan.

Second, the Councils objected to a requirement that individuals be "medically stable" to receive services. DMMA removed the provision which had been included in error.

Third, the Councils questioned a bar on ASD services if an individual qualifies for ICF/IID placement. DMMA removed the reference which had been included in error.

Fourth, the Councils questioned why the projected fiscal impact was so high. DMMA provided its rationale for the projection which is based on 111 clients receiving services during a 6-month period.

Fifth, the Councils questioned the need for a comprehensive evaluation as a precondition of qualifying for services. DMMA modified the requirement. See p. 15.

Sixth, the Councils questioned a bar on an ASD evaluator providing ASD services. DMMA agreed and removed the bar on the evaluator also providing services.

Seventh, the Councils recommended adding the individual with ASD as a source of information for the Functional Behavioral Assessment. DMMA agreed and incorporated conforming language.

Eighth, the Councils recommended the addition of a reference to an advance practice nurse. DMMA added the reference.

Ninth, the Councils recommended substitution of "individual" for "child" in one section. DMMA responded that it was changing all references to "individual" to "child" throughout the document.

Tenth, the Councils strongly objected to a categorical requirement that a caregiver be present during provision of all services. DMMA removed the provision while adopting revised language.

Eleventh, the Councils questioned adoption of a limit of 25 hours of ASD treatment services weekly which could be exceeded only with prior authorization. DMMA retained the prior authorization approach but increased the threshold to 40 hours of services weekly prior to triggering the prior authorization requirement.

The adoption of the above amendments result in significant improvement of the standards and generally merit endorsement. However, I identified the following concerns with the current version of the proposed regulation:

A. On p. 14, the original regulation referred to "services to treat Autism Spectrum Disorder (ASD)". The new regulation substitutes "behavioral interventions to treat Autism Spectrum Disorder (ASD)". At 14. The latter terminology ("behavioral interventions") is more limited than "services". For example, interventions would generally not include diagnostic services. See, e.g., disjunctive reference to "diagnosing or treating ADD" on p. 15. Moreover, ASD treatment is not limited to modification of "behavior". Finally, consistent with 42 C.F.R. 440.130(c), the attached July 7, 2014 CMS guidance uses the term "services" rather than "interventions". I recommend reverting to the original language.

B. As outlined under "Tenth" above, the Councils prompted DMMA to remove a categorical provision requiring caregiver presence whenever ASD services are provided. However, the new approach (p. 19) is objectionable. It confers unilateral control over caregiver participation/implementation of the service plan to a "practitioner": "The practitioner must specify the expected level of participation of all caregivers, based on the practitioner's clinical judgment and the child's unique circumstances, as specified in the Behavior Support Plan or ABA Treatment Plan." No single individual controls the content of the Behavior Support Plan or ABA Treatment Plan. The plans should be developed collaboratively and incorporate the input and views of multiple practitioners and caregivers. I recommend substitution of the following sentence: "The expected level of participation of all caregivers shall be included in the Behavior Support Plan or ABA Treatment Plan." Note that Par (8) on the same page already requires the plan to include the extent of parent or guardian participation. However, a single practitioner does not "trump" decision-making in this context.

C. DMMA may wish to correct the grammar in the following provision on p. 20: “Medicaid shall not cover for program services or components of services that are of an unproven, experimental, of a research nature, or that do not relate to the child’s diagnosis, symptoms, functional limitations or medical history.”

The Councils may wish to share the above observations with the Division with a courtesy copy to Autism Delaware.

4. DOE Prop. Public, Private, & Nonpublic School Definitions Reg. [20 DE Reg. 9 (7/1/16)]

The Department of Education proposes to modify its regulation defining types of schools. I have two (2) observations.

First, in §2.0, the definition of “charter school” generally conforms to statute. See 14 Del.C. §503. However, the DOE may wish to embellish the definition to conform to another DOE regulation, 14 DE Admin Code 2.0, which recites as follows:

“Charter School” means a non-home based full time public school that is operated in an approved physical plant under a charter granted by, or transferred to the Department with the approval of the State Board for the personal physical attendance of all students.

[emphasis supplied]

The underlined language clarifies that a charter school cannot be an Internet or Cyber school with students participating from remote locations. The proposed definition omits this limitation. The DOE could consider the following amendment:

“Charter School” means a non-homebased public school including two or more of grade kindergarten through twelve, operated in an approved physical plant for the personal physical attendance of all students, which is managed by a board of directors.

Second, in §2.0, the definition of “Reorganized School District or School District”, includes the following sentence: “This definition may also include vocational/technical school districts.” This creates ambiguity. Either Vo-tech districts are included in the definition or not. Reciting that Vo-tech districts “may” be included in the definition will lead to confusion and a lack of clarity.

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

Attachments

JUN 24 2016



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

DATE: June 2, 2016

TO: Daniese McMullin-Powell
Chairperson
State Council for Persons with Disabilities
410 Federal Street, Suite 1
Dover, DE 19901

FROM: Glyne Williams, DMMA
Planning, Policy and Quality Unit

RE: 19 DE Reg. 987 [DMMA Proposed Spousal Impoverishment Undue Hardship Regulation (5/1/16)]

Thank you for your recent memorandum regarding the Division of Medicaid and Medical Assistance (DMMA) notice soliciting comments on its proposal to adopt a provision that allows the spousal impoverishment regulation to be waived in the instance of undue hardship. The proposed regulation was published as 19 DE Reg. 987 in the May 1, 2016 issue of the Register of Regulations. DMMA has considered your comments and responds as follows.

You write,

Background on "spousal impoverishment" is summarized in the attached Medicaid.gov overview:

The expense of nursing home care - which ranges from \$5,000 to \$8,000 a month or more - can rapidly deplete the lifetime savings of elderly couples. In 1988, Congress enacted provisions to prevent what has come to be called "spousal impoverishment," leaving the spouse who is still living at home in the community with little or no income or resources. These provisions help ensure this situation will not occur and that community spouses are able to live out their lives with independence and dignity.

There is a federal minimum resource standard which is updated annually. In 2016, it is \$23,844. States can exceed the federal minimum. Delaware adopted a standard of \$25,000 in 1993.

Federal law, 42 U.S.C. 1396r-5(c)(3) directs states to disregard otherwise countable spousal resources if "the State determines that denial of eligibility would work an undue hardship." DMMA's current regulations implement this law:

An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible per Section 1924(c)(3) C of the Social Security Act where the state determines that denial of eligibility on the basis of having excess resources would work an undue hardship. (16 DE Admin Code 20950. See also 19 DE Reg. at 989.)

DMMA proposes to adopt the following definition of "undue hardship":

20900.1. Undue Hardship

Spousal Impoverishment rules may be waived if the application of the rules would cause an undue hardship. Undue hardship exists when application of the spousal impoverishment provisions would deprive the individual of medical care such that his/her life would be endangered. Undue hardship also exists when application of the spousal impoverishment provisions would deprive the individual of food, clothing, shelter or other necessities of life.

SCPD has the following observations.

First, DMMA should consider an increase in the \$25,000 resource cap adopted in 1993. Consistent with the attachment, \$25,000 in 1993 is equivalent to \$41,199 in 2016. If raised, there would be less need to consider a waiver.

Agency Response: DMMA thanks the Council for its comment. However, as you noted, DMMA has an Undue Hardship provision in place to protect against a finding of ineligibility for long-term care (LTC) as a result of the calculation of a couple's countable resources at DSSM 20950, which states the following:

An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible per Section 1924 (c)(3)(C) of the Social Security Act where the state determines that denial of eligibility on the basis of having excess resources would work an undue hardship.

In addition, the Community Spouse Resource Allowance (CSRA) is the amount of resources equal to whichever is greater: \$25,000 OR ½ the value of the couple's combined countable resources as of the beginning of the first continuous period of institutionalization on or after 09/30/89, but no more than the current maximum resource allowance determined by Federal law. The current maximum resource allowance for 2016 is \$119,220.00. Therefore, \$25,000 is not the maximum amount of resources allowable for a couple applying for LTC.

This proposed change in LTC eligibility policy would exempt an applicant who is legally married from having spousal impoverishment regulations applied in his or her request for LTC services. Current policy requires that spousal impoverishment regulations be applied to all legally married couples unless the couple is separated and maintains two separate residences for at least 12 months prior to admission to a medical institution AND the community spouse is uncooperative or his/her whereabouts are unknown. This proposed change in eligibility policy provides additional protection for married individuals in unique situations, who do not meet the current exemptions to the application of spousal impoverishment regulations, and who would be unfairly penalized for the non-cooperation of a spouse.

There was no change made to the regulation as a result of this comment.

Second, the proposed standard is unduly limiting. Medical expenses can qualify for consideration in the "undue hardship" determination only if the individual would die without the medical care. CMS is more expansive, authorizing an "undue hardship" waiver if the person's health would be endangered. See, e.g. the attached CMS Deficit Reduction Act (DRA) summary and conforming Pennsylvania policy. Thus, if the loss of medical care would result in excessive pain; loss of a limb; partial paralysis; exacerbation of a diagnosed mental health condition (e.g. depression; schizophrenia); or other deterioration in health, the DMMA workers should be able to consider such effects. Moreover, it would be preferable to modify the third sentence as follows: "Without limitation, undue hardship also exists when application....life." There should be some recognition that genuine hardship may be presented by factors beyond a short list. For example, a blind individual with an aging seeing-eye dog may need funds for dog food and expensive veterinary care.

Agency Response: DMMA thanks the Council for its comment. However, DMMA respectfully disagrees with the statement that the undue hardship eligibility policy provisions are unduly limiting. DMMA believes that this proposed eligibility policy provides additional protections for married individuals in difficult situations. This policy provides additional protections to this population that did not previously exist under prior spousal impoverishment regulations. DMMA believes that this proposed change in eligibility policy will prevent this group of individuals from being determined ineligible for LTC services due to circumstances beyond their control.

There was no change made to the regulation as a result of this comment.

Thank you again for your review and feedback related to the suggested changes in Medicaid LTC eligibility policy on Spousal Impoverishment. DMMA is pleased to provide the opportunity to receive public comments and greatly appreciates the thoughtful input given.

Cc: Stephen M. Groff, Director, DMMA



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES

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May 25, 2016

Mr. Chris Kenton, Executive Director
Professional Standards Board
Townsend Building
401 Federal Street – Suite 2
Dover, DE 19901

RE: 19 DE Reg. 979 [PSB Proposed School Nurse Regulation (5/1/16)]


Dear Mr. Kenton:

The State Council for Persons with Disabilities (SCPD) has reviewed the Professional Standards Board's [in collaboration with the Department of Education (DOE)] proposal to adopt some discrete revisions to its school nurse standards. The rationale is as follows: "This regulation requires some formatting changes to conform to other Standard Certificates and the updating of certification requirements." At 979. The proposed regulation was published as 19 DE Reg. 979 in the May 1, 2016 issue of the Register of Regulations. SCPD has the following observation.

The Department may wish to reconsider §6.2. That section requires public schools to be responsible "for verifying that the School Nurse continues to meet the requirements" in certain subsections. The reference to §4.1.1 seems inapt since a nurse will not "lose" a degree. On the other hand, it may be logical to include a reference to §4.1.4 since the 90 hours of mandatory training would occur subsequent to hiring. Therefore, the DOE could consider substituting "subsections 4.1.2 through 4.1.4" for "subsections 4.1.1 through 4.1.3" in §6.2.

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

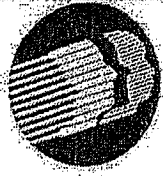
Sincerely,


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

cc: The Honorable Steven Godowsky, Ed.D, Secretary of Education
Ms. Tina Shockley, Department of Education
Dr. Teri Quinn Gray, State Board of Education
Ms. Mary Ann Mieczkowski, Department of Education
Ms. Laura Makransky, Esq., Department of Justice
Ms. Terry Hickey, Esq., Department of Justice
Ms. Valerie Dunkle, Esq., Department of Justice
Mr. Brian Hartman, Esq.
Developmental Disabilities Council
Governor's Advisory Council for Exceptional Citizens

19reg979 PSB school nurse 5-1-16

JUN 24 2016



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

DATE: May 17, 2016

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

FROM: Glyne Williams, DMMA
Planning, Policy and Quality Unit

RE: 19 DE Reg. 898 [DMMA Proposed Medicaid Autism Services Disorder Regulation (4/1/16)]

Thank you for your recent memorandum regarding the Division of Medicaid and Medical Assistance (DMMA) notice soliciting comments on its proposal to amend the Medicaid State Plan to address coverage and reimbursement of treatment services for beneficiaries up to age 21 with a diagnosis of autism spectrum disorder (ASD). The proposed regulation was published as 19 DE Reg. 898 in the April 1, 2016 issue of the Register of Regulations. DMMA has considered your comments and responds as follows.

You write,

As background, CMS issued the attached July 7, 2014 guidance outlining approaches to provide Medicaid services to eligible individuals with ASD. CMS noted that services often "fit" under the following categories: 1) other licensed practitioner services; 2) preventive services; 3) therapy services; 4) waivers; and 5) EPSDT benefit. See also related articles. DMMA is now implementing the guidance by adopting conforming Medicaid State Plan amendments. SCPD has the following observations.

First, there is some "tension" between the proposed requirement that a Medicaid beneficiary be "under 21 years of age" to qualify for "autism spectrum disorder treatment services" (p. 900) and special education eligibility extending to the end of the school year in which a student turns 21. See Title 14 Del.C. §3101(1). The age standard is ostensibly based on the EPSDT age limit but EPSDT should not be the sole eligibility basis for autism-related services. Moreover, "other licensed practitioner services", "preventive services", and "therapy services" are not limited to individuals under age 21.

Agency Response: This is an EPSDT State Plan Amendment for the purpose of enumerating the services, provider qualifications, and reimbursement methodology for assessment and treatment services for individuals under 21 who are diagnosed with Autism Spectrum Disorder. It is limited to individuals

under the age of 21. States have latitude in including such provisions in either the EPSDT section of the Medicaid State Plan or a service-specific section. Based on a review of how other states have addressed these EPSDT services, DMMA decided to put this in the Preventive Services section of the State Plan.

Second, ASD services are barred if an individual is not "medically stable" (p. 900). Therefore, individuals with the most severe medical needs are anomalously ineligible for services. For example, query whether a beneficiary would be unable to obtain occupational or physical therapy services to remediate an "unstable" medical condition (e.g. helmet or assistive technology to address head banging or SIBS). Conceptually, the autism treatment services may be necessary to achieve medical stability.

Agency Response: This statement was included in the summary of the regulation in error and is not reflected in the service specifications and limitations in the actual state plan amendment language. DMMA has removed that language from the summary that will accompany the re-proposed publication in the July 1, 2016 Delaware Register.

Third, ASD services are barred if an individual qualifies for ICF/IID placement (p. 900). This would ostensibly exclude anyone enrolled in the DDDS waiver (in which eligibility begins at age 12) which categorically requires that participants meet an ICF/IID level of care. See attached excerpts from DDDS waiver.

Agency Response: This statement was included in the summary of the regulation in error and is not reflected in the service specifications and limitations in the actual state plan amendment language. DMMA has removed that language from the summary that will accompany the re-proposed publication in the July 1, 2016 Delaware Register.

Fourth, the projected fiscal impact of the regulation is high, i.e., \$1,223,105 in State funds in FFY17 (p. 901). Since the identified services (other licensed practitioner services; preventative services; therapy) are already covered by the State Plan, it's unclear why the projected fiscal impact is so high. Moreover, since private insurers must cover treatment of autism spectrum disorders (S.B. No. 22 from 146th General Assembly), private insurance should cover most services if an individual has both Medicaid and private health insurance.

Agency Response: These are currently covered services; however, by providing this additional clarification and further defining available coverage, families will have clarity around what services are available to children who are eligible. It is true the legislation will provide additional benefits however, there is a cap associated with the private insurance benefit. Thus private insurance will not cover all of ASD services children need. The fiscal impact was based on treating 111 clients. Each client would receive an assessment, treatment plan, and services. The fiscal year 2016 was prorated for a half year start time.

Fifth, an individual cannot obtain a functional behavioral assessment, a behavioral support plan, or any ASD treatment services until a licensed medical professional under Delaware State regulation completes an evaluation. See Attachment 3.1-A, Page 6 Addendum 1a. This categorical requirement appears unduly strict if an individual with an ASD diagnosis for years, perhaps based on an out-of-state evaluation, desires a behavioral support plan or ASD services.

Agency Response: The intention of the requirement for a medical/physical evaluation and a comprehensive diagnostic evaluation is not to delay either the receipt of medically necessary ASD services but rather to ensure that an individual receiving services under this section of the State Plan has a diagnosis of ASD from a provider who is qualified to make such a diagnosis and to rule out other causes of behaviors that mimic ASD for which ADS services may not be the appropriate course of treatment. In response to several similar comments regarding the requirement for a comprehensive diagnostic evaluation being a barrier to necessary treatment services because of the lack of qualified providers who can conduct such evaluations, DMMA has removed the requirement for the comprehensive diagnostic evaluation. DMMA continues to assert, however, that confirming a diagnosis of ASD and ruling out other causes of behaviors is a best practice designed to ensure that recipients receive services appropriate to their diagnosis.

Sixth, there is some "tension" between the following requirements:

These evaluations may not be performed by the same professional who delivers or supervises the beneficiary's direct ASD treatment.

Attachment 3.1-A, Page 6 Addendum 1b (describing neurodevelopmental review by psychologists and psychiatrists).

The provider who develops the behavioral plan of care should be the same provider who performed the behavioral assessment, except in extenuating circumstances, ...

Attachment 3.1-A, Page 6 Addendum 1g.

As a practical matter, it may be impractical and counterproductive to exclude an evaluator from also providing services. This is not the standard model within the Delaware Medicaid program. For example, an ST, OT, or PT often performs an assessment of need, develops a treatment plan, and provides therapy pursuant to the plan.

Agency Response: In response to several comments, DMMA has removed the requirement that the provider who performs the evaluation may not provide either the ASD assessment or treatment services, as DMMA agrees that this could limit the pool of qualified providers within a segment of the healthcare market that is already limited.

Seventh, the sources of information for the functional behavioral assessment include everyone but the individual with the ASD diagnosis. See Attachment 3.1-A, Page 6, Addendum 1c. It would be preferable to include the individual in the list which otherwise includes schools, family, pediatricians, etc.

Agency Response: DMMA has added this individual as a source of information for the Functional Behavioral Assessment in the re-proposed state plan amendment language.

Eighth, DMMA may wish to amend the following provision in Attachment 3.1-A, Page 6, Addendum 1d by adding the underlined language: "(6) The use of Behavior Modifying Medications without a formal assessment and diagnosis of a corresponding mental health disorder by physician or advance practice registered nurse ." See 24 Del.C. §1902.

Agency Response: DMMA has revised Attachment 3.1-A, Page 6, Addendum 1d by adding the underlined language: “(6) The use of Behavior Modifying Medications without a formal assessment and diagnosis of a corresponding mental health disorder by physician or advance practice registered nurse.

Ninth, in Attachment 3.1-A, Page 6 Addendum 1e, Par (12), DMMA may wish to substitute “individual” for “child”.

Agency Response: DMMA has changed all applicable references from individual to child in the re-proposed state plan amendment language.

Tenth, the following requirement is highly objectionable:

(e) Presence/Availability of Caregiver. In order to ensure that the services are covered under the preventive services benefit category and do not include non-coverable services such as child care, respite, or related services, as well as to ensure the clinical success of the services, a caregiver must be present and/or available in the setting where services are being provided at all times (even when not directly participating in the services) in order to care for individuals under the age of eighteen.

Attachment 3.1-A, Page 6 Addendum 1f.

This is a discriminatory requirement which “stereotypes” all individuals under 18 with an ASD diagnosis as requiring 24/7 care under constant adult supervision. It is not required that parents of minors with other conditions be physically present on-site when a minor receives Medicaid services. There are 17 year old individuals with Aspergers who could drive themselves to an appointment and have absolutely no need for parental accompaniment. Moreover, the statement that “respite” is categorically a “non-coverable” service is incorrect. It is a covered service under the DSHP+ program and may be available under the EPSDT benefit.

Agency Response: DMMA has removed the existing language regarding caregiver presence and replaced it with language indicating that the amount of caregiver participation in treatment activities will be determined by the ASD service provider. The provider will base this participation on the individual circumstances of each case and will be described in the treatment plan. With regard to respite services, this is not an allowable EPSDT benefit.

Eleventh, the following utilization limit is highly objectionable:

(f) Limitations on ASD Treatment Services: Total ASD treatment services from all sources may only be the amount medically necessary for each individual, up to 25 hour (sic “hours”) per week, which may be exceeded with prior authorization based on medical necessity.

Attachment 3.1-A, Page 6 Addendum 1f.

A. This limitation is at odds with the EPSDT expectation that covered individuals will receive all Medicaid services needed to ameliorate conditions identified through screening and assessment. See Attachment 3.1-A, Page 6 Addendum 1. See also attached CMS EPSDT guidance:

The goal of this benefit is to ensure that children under the age of 21 who are enrolled in Medicaid receive age-appropriate screening, preventive services, and treatment services that are medically necessary to correct or ameliorate any identified conditions - the right care to the right child at the right time in the right setting. This broad scope supports a comprehensive, high-quality health benefit.

NHeLP characterizes attempts to place hard caps on ASD services as illegal under EPSDT:

Another common problem is that some states place hard limits on the hours of service Medicaid will provide in a week or a month. These limits, which are illegal under EPSDT, prevent children with the highest need from getting all the medically necessary care to which they are entitled. (See CMS, EPDST Coverage Guide at 23).

NHeLP, "Autism Spectrum Disorders", Health Advocate (October, 2015) at 3 (attached).

The CMS EPSDT Guide is corroborative:

Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements. ...For example, while a state may place in its State Plan a limit of a certain number of physical therapy visits per year for individuals age 21 and older, such a "hard" limit could not be applied to children.

At 23-24 (attached). Although CMS suggests some leeway with "soft" limits incorporated into medical necessity standards, DMMA is not amending its medical necessity regulation. Rather, it is manifestly imposing a cap based on budgetary considerations.

B. There is no comparable cap on ST, OT, or PT, preventive services, and other licensed practitioner services in the Medicaid State Plan generally so imposing a cap simply because a beneficiary has an ASD diagnosis is ostensibly impermissible discrimination under the ADA and Section 1557 of the ACA. See attachment.

Agency Response: DMMA agrees that hard limits cannot be applied to EPSDT services. However, the limitation proposed in the regulation is not a hard limit, but rather, the threshold above which prior authorization is required. According to the CMS manual EPSDT - A Guide for States, June 2014, "states may impose utilization controls to safeguard against unnecessary use of care and services. For example, a state may establish tentative limits on the amount of a treatment service a child can receive and require prior authorization for coverage of medically necessary services above those limits." This is what DMMA has chosen to do in this case. DMMA will monitor the receipt of ASD services and will ensure that the prior authorization procedures do not delay the delivery of needed treatment services.

Regarding the proposed limit of 25 hours per week, above which prior authorization is required, a number of commenters object to this threshold as not being consistent with best practice as articulated by the Behavior Analyst Certification Board (BACB). DMMA has re-evaluated that threshold and has determined that forty (40) hours per week is a more appropriate threshold. This change has been made to the re-proposed state plan amendment pages.

DMMA is pleased to provide the opportunity to receive public comments and greatly appreciates the thoughtful input given. Due to the substantial comments received and subsequent changes to the proposed regulation, DMMA will publish this regulation as re-proposed in the July 1, 2016 Delaware Register to allow for further review and an additional thirty (30) day comment period.

Cc: Stephen M. Groff, Director, DMMA