



DISABILITIES LAW PROGRAM

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MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory Initiatives

Date: November 8, 2017

Consistent with the request of multiple councils, I am providing analyses of sixteen (16) regulatory initiatives appearing in the November, 2017 issue of the Register of Regulations. Given time constraints, the analyses should be considered preliminary and non-exhaustive.

1. DMMA Final Care Expense Deductions Regulation [21 DE Reg. 435 (11/1/17)]

The SCPD and GACEC commented on the proposed version of this regulation in September, 2017. A copy of the September 28, 2017 SCPD memorandum (minus attachments) is appended for facilitated reference.

In a nutshell, the Councils endorsed the initiative since it benefitted Medicaid enrollees receiving HCBS or institutional services with little fiscal impact. The Division of Medicaid & Medical Assistance (DMMA) has now acknowledged the endorsements and adopted a final regulation which conforms to the proposed version.

Since DMMA has adopted a final regulation endorsed by the Councils, no further action appears warranted.

2. DMMA Final "Psych Under 21" Reimbursement Regulation [21 DE Reg. 438 (11/1/17)]

The SCPD and GACEC commented on the proposed version of this regulation in September, 2017. A copy of the September 28, 2017 SCPD memorandum (minus attachments) is appended for facilitated reference.

The Councils identified three (3) concerns.

First, the Councils proffered a revised version of a standard applicable to out-of-state facilities. The Division agreed and adopted the Councils' recommended revision verbatim.

Second, the Councils suggested a few grammatical corrections. The Division adopted the recommended changes.

Third, the Councils recommended the addition of an authorization for out-of-state facility reimbursement for "activities in the plan of care but not in the per diem". The Division agreed and incorporated a conforming revision.

Since the regulation is final, and the Division adopted revisions consistent with all of the Councils' comments, no further action appears warranted.

3. DMMA Final DPAP Elimination Regulation [21 DE Reg. 433 (11/1/17)]

The SCPD and GACEC commented on the proposed version of this regulation in August, 2017. A copy of the August 23, 2017 SCPD memorandum (minus attachments) is appended for facilitated reference.

The Councils noted that the State enabling legislation for the Delaware Prescription Assistance Program (DPAP) had already been repealed so the regulation was merely implementing that repeal. However, the Councils questioned the rationale/justification for the repeal. Later, the attached September 1, 2017 News Journal article was published which reinforced the Councils' concern. It reports that 5,300 Delawareans were affected by the repeal.

The Division has now adopted a final regulation acknowledging the Councils' comments and providing some additional information.

In response to the Councils' solicitation, DMMA provided additional background information on the effect of the repeal. At 435. First, the DPAP covered over-the-counter medications. Medicaid Part D does not cover over-the-counter medications. Second, the DPAP covered some prescription drug costs during the annual Part D deductible period (approximately \$400 in 2017). Third, DPAP covered some of the costs during the Part D coverage gap (a/k/a the "donut hole"). Fourth, the DPAP assisted with payment of Medicare D premiums.

In response to the Councils' solicitation, the DMMA also provided copies of the last three annual reports on the program.

Since the DPAP program was repealed as part of the FY18 budget, the adoption of the implementing regulation is essentially a "housekeeping" measure. No further action appears warranted.

4. DMMA Final Medicaid Dental Fee Schedule Regulation [21 DE Reg. 430 (11/1/17)]

The SCPD and GACEC commented on the proposed version of this regulation in August, 2017. A copy of the August 29, 2017 SCPD memorandum (minus attachments) is attached for facilitated reference.

The Councils shared the results of independent research corroborating the Division's view that there existed ample justification to reduce the reimbursement rate for child dental care. The Councils also noted that the rate reduction had already been incorporated into the FY18 budget. Therefore, the regulation was essentially a "housekeeping" measure. Finally, the Councils recommended consideration of using the \$2.6 million in savings due to the lower reimbursement rate to support adult dental services.

The Division has now acknowledged the comments and adopted a final regulation which conforms to the proposed version. No further action appears warranted.

5. DOE Final Foster Care Student Placement Regulation [21 DE Reg. 420 (11/1/17)]

The SCPD and GACEC commented on the proposed version of this regulation in September, 2017. A copy of the September 28, 2017 SCPD letter (minus attachments) is appended for facilitated reference. The Department of Education has now adopted a final regulation with a few revisions prompted by the commentary.

First, the Councils recommended that the regulation be amended to include the following consideration required by the applicable federal regulation: "the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement." The DOE declined to amend the regulation while noting that the above consideration is included in the Best Interest Meeting Determination Form. At 420-421.

Second, the Councils observed that the application of the regulation only to foster children was narrower than the enabling law. The DOE issued a confusing comment and then narrowed the regulation further:

Comments were received regarding the applicability of the regulation to the enabling Delaware statute. The Department considered the comment and determined that the specific provision in the current law controls. The regulation was amended for clarification that the regulation applies to students in foster care in accordance with the specific provisions in the law.

21 DE Reg. at 421. This makes little sense since the law does not mention foster care.

Third, the Councils noted that the regulation incorrectly presumes that all children in DSCY&F custody are in DFS custody. The DOE does not address the comment but amended the regulation to limit its application to children in DSCY&F custody who are “in foster care”. At 421.

Fourth, the Councils noted that the role of charter schools in the regulatory scheme was unclear. The DOE responded with the following unresponsive, cryptic comment:

Comments were received regarding applicable to charter schools in 3.1.3. A charter school operates under a single charter regardless of grade configuration.

20 DE Reg. At 421.

Fifth, the Councils characterized a 10 working day period to notify DOE of the inability to schedule a “Best Interest Meeting” as too long. The DOE responded as follows:

Comments were received regarding the timing of the notification of the Department related to the inability of the Best Interest meeting to be schedule (sic “scheduled”) under the required timeline provisions. This notification does not affect the provision of services.

Id. Since the student’s placement affects services, the comment is inaccurate.

Sixth, the Councils recommended that the parent or educational representative should be included as decision-makers in the Best Interest Meeting. The DOE did not respond to the comment but added “educational surrogate parent” (but not natural parent) to the list of invitees to the meeting. At 423.

Seventh, the Councils recommended inclusion of a notice of appeal rights and resolution of conflicts between the identified decision-making system and the decision-making systems under Section 504 and the IDEA. The DOE responded that “(c)larification was made to address the applicability of other federal laws.” At 421. The Department then added inapposite sections from its homebound/supportive instruction regulation to the end of this regulation.

Since the regulation is final, and the prospects for apt revisions are dim, no further action appears warranted.

6. DMMA Proposed Medicaid Excluded Income Regulation [21 DE Reg. 392 (11/1/17)]

The Division of Medicaid & Medical Assistance (DMMA) proposes to adopt a discrete amendment to the Delaware Social Services Manual (DSSM).

As background, the Affordable Care Act (ACA) defines countable income for certain Medicaid populations based on “modified adjusted gross income (MAGI). At 393. In September, 2016 CMS issued guidance as a supplement to a 2013 training manual providing recommended language “that can be used to make the income counting rules more clear for eligibility workers”. *Id.* Consistent with the guidance, DMMA is now revising a single regulation to list types of excluded income from the MAGI calculation. At 394. The regulation appears to be relatively straightforward and includes SSI, child support, Worker’s Compensation, and TANF in the list of excluded income. There is no State fiscal impact as a result of adoption of the regulation. *Id.*

The Councils may wish to consider an endorsement.

7. DMMA Proposed Medicaid Managed Care Reg [21 DE Reg. 389 (11/1/17)]

The Division of Medicaid & Medical Assistance (DMMA) proposes to amend the Delaware Social Services Manual (DSSM) to conform to CMS Medicaid managed care regulations published on May 6, 2016.

I have the following observations.

First, in proposed §5305 on p. 391, the citation to 42 CFR 438.208(f)(2) is incorrect. The reference should be to 42 CFR 438.408(f)(2).

Second, it appears that a word and/or punctuation may have been omitted in §3.1.2 on p. 392. It currently reads as follows:

3.1.2 Audited financial statements for the most recent calendar or fiscal year demonstrating, on a consolidated basis, generally accepted accounting principles and generally accepted auditing standards net equity in excess of \$10 million.

The Division could consider the following alternative:

3.1.2 Audited financial statements for the most recent calendar or fiscal year demonstrating, on a consolidated basis, **[utilizing]** generally accepted accounting principles and generally accepted auditing standards **[,]** net equity in excess of \$10 million.

Third, DMMA is adopting a piecemeal approach to revising the MCO appeal/fair hearing standards to be effective on January 1, 2018:

DMMA is moving forward with implementation of provisions of the Final Rule effective as of January 1, 2018.

20 DE Reg. at 389.

Effective for services provided on and after January 1, 2018 Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) proposed to amend the Division of Social Services Manual regarding Medicaid Managed Care Final Rule, specifically to align DMMA Medicaid Managed Care Policy with new Federal Requirements.

20 DE Reg. at 390.

Consistent with the attached excerpt from the CMS regulations, “(s)tates must comply with the [MCO appeal/fair hearing] requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.”

The problem with a “piecemeal” approach is that the federal regulations create an interrelated system. If DMMA only adopts a few standards, and omits others, it will not have an integrated system on January 1, 2018. Moreover, unless DMMA publishes an emergency regulation, it is too late to issue a proposed regulation which would be final on January 1, 2018. For example, proposed §5305 contains the following new subsection:

E. Recipients enrolled in a MCO

A hearing is granted if the request is received within 120 calendar days from the date of the MCO’s notice of an appeal resolution upholding an adverse benefit determination. If the request is not received during the timely notice period, the adverse benefit determination is to take effect.

This ignores the CMS regulation authorizing a beneficiary to appeal an adverse benefit determination without an MCO notice of appeal if the MCO has failed to adhere to notice and timing requirements [42 CFR 438.408(f)(1)].

The regulatory scheme is also unclear on “who” can request a fair hearing. The applicable CMS regulation [42 CFR 438.402] allows states to authorize providers to request a fair hearing with beneficiary consent. Current DHSS standards ostensibly authorize a provider to request an expedited MCO internal hearing/review but are unclear on whether a provider can request a fair hearing. See 16 DE Admin Code 5304.3.

The current DMMA regulation [16 DE Admin Code 5304.3] allows MCOs to conduct internal hearings and issue a decision within 45 days. This conflicts with the applicable CMS regulation [42 CFR 438.408] establishing a maximum 30-day time period for a decision.

The same DMMA regulation [16 DE Admin Code 5304.3] does not differentiate between grievances and appeals. The same CMS regulation [42 CFR 438.408] clearly differentiates between grievances and appeals.

The bottom line is that, on January 1, 2018, the DMMA regulatory scheme will not be uniformly consistent with the CMS standards. This may create confusion among beneficiaries, providers, advocates, and MCOs.

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

8. DMMA Prop. Child Care Redetermination Regulation [21 DE Reg. 374 (11/1/17)]

The Department of Health & Social Services maintains a program covering the costs of child care for individuals meeting certain program and financial standards. Eligibility is generally open to the following: 1) TANF beneficiaries who are employed, attending school, or participating in vocational programs; 2) low income working families; 3) low income families involved with job training or education programs; 4) some Food Supplement program beneficiaries; 5) families receiving DFS protective services; and 6) eligible families with a special needs parent or child. See 16 DE Admin Code §§11002.4 and 11003.7.8. The State “special needs” regulations are attached for facilitated reference.

The Division of Medicaid & Medical Assistance is proposing to amend its regulations to conform to federal regulations published at 81 Fed Reg 67438 (September 30, 2016). Copies of the relevant background section of the regulations (81 Fed Reg 67461-67469) and the current federal regulation (45 CFR 98.21) are attached.

In a nutshell, participants exceeding the normal financial eligibility cap are essentially given an extended, 12-month period of eligibility if their countable income is between 185-200% of the Federal Poverty Level (FPL) but below 85% of the State’s Median Income (SMI). The purpose of the “graduated phase out” is to allow families to transition gradually from receiving subsidized child care rather than facing abrupt termination.

The Division projects a State fiscal impact of \$2 million in FFY18 whose impact is partially offset by \$6 million in federal funds. At 375.

Since the State is required to implement the federal regulation, and the revision benefits program participants (including “special needs” parents and children), the Councils may wish to consider endorsement.

9. DMMA Proposed Relative Child Care Regulation [21 DE Reg. 376 (11/1/17)]

The Division of Medicaid & Medical Assistance (DMMA) proposes to revise its subsidized child care regulations. The Councils previously commented on related regulations published at 20 DE Reg. 412 (12/1/16) and 20 DE Reg. 614 (2/1/17).

The Division proposes to restrict relative child care to conform to its view of the original intent, i.e., to provide a child care option for parents who work during “non-traditional” hours (e.g. shift work; weekends). Moreover, although relative caregivers may be exempt from licensing, the State is required to implement health and safety standards for all providers. This has prompted DMMA to propose new training and capacity standards. Some of the standards implement the attached 45 CFR 98.41.

I have the following observations.

First, there is an ostensible error in Section 5 on p. 378. The first bullet literally allows care in a child’s home only for 4-5 children. The reference to “minimum of four children in the home” should be “minimum of one child in the home”. Compare Section 6.

Second, Section 3 requires a relative provider to be “21 years of age or older”. In contrast, the applicable federal regulation defines relative child care providers as “18 years of age or older”. See 45 CFR 98.2. Moreover, states are restricted in their discretion to add requirements not included in the federal regulations:

(b) Lead agencies may not set health and safety standards and requirements other than those required in paragraph (a) of this section that are inconsistent with the parental choice safeguards in §98.3(f).

45 CFR 98.41(b).

Third, Section 3 includes the following limit: “Relative child care is limited to evening and weekend shift work hours only.” This is ill- conceived given the overall shortage of child care providers. Moreover, “special needs” parents and children are eligible for the State child care program. See 16 DE Admin Code 11003.7.8. It may be extremely difficult for a parent of a special needs child ages 13-18 to identify a licensed provider to add a 13-18 year old to their daycare. Moreover, “special needs” parents often rely on relatives for parenting assistance and federal law requires states to accommodate that reliance. See Joint DOJ/HHS LOF to Mass. Dept. Of Children & Families (1/29/15), published at https://www.ada.gov/ma_docf_lof.pdf. See also U.S. DOJ/HHS Joint Guidance, “Protecting the Rights of Parents and Prospective Parents with Disabilities: Technical Assistance for State and Local Child Welfare Agencies and Courts under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act (8/15)”, published at https://www.ada.gov/doj_hhs_ta/child_welfare_ta.pdf. At a minimum, Section 3 should be revised to allow relative child care for special needs children and adults apart from evening and weekend shifts.. It would also be prudent to authorize exceptions for all parents with the approval of DHSS.

Fourth, DMMA is imposing the following requirements on relative providers: 1) completion of orientation class on relative child care rules and regulations; 2) 28 hours of approved training within 12 months; 3) 3 hours of health and safety training annually; and 4) completion of both CPR and first aid courses resulting in certification followed by recertification every 2 years. See Section 4. DMMA is treating relative child care providers as if they were licensed day care providers even though they are exempt from licensing. See 16 DE Admin Code 11004.4.1. Asking a typical grandparent to spend an estimated 40 hours in training to care for a grandchild is “overkill”.

The Councils may wish to consider sharing the above observations with the Division. In the Councils’ discretion, courtesy copies could be shared with UCP; the Arc; Autism DE; Steve Yeatman (DSCY&F & DDC); Rick Kosmalski (DDDS & DDC); Sen. Poore; and Rep. Heffernan.

10. DMMA Prop. Special Need Trust Regulation [21 DE Reg. 387 (11/1/17)]

The Division of Medicaid & Medical Assistance proposes to amend the special needs trusts sections of the Delaware Social Services Manual (DSSM).

Background is provided in the attached August 2, 2017 CMS guidance. Historically, a parent, grandparent, guardian, or court could establish a special needs trust containing the assets of an individual under age 65 with a disability. To qualify as an exempt asset for purposes of Medicaid, the trust was required to direct repayment of all medical assistance paid by the state on the individual’s behalf upon the individual’s death.

Section 5007 of the federal CURES Act amended the special needs trust standards to allow a beneficiary to establish such a trust in addition to a parent, grandparent, guardian or court. The new authorization is effective for trusts established on or after December 13, 2016.

DMMA is now amending its regulations to conform to the change in federal law. However, the revision to §20400.9.1 is grammatically incorrect and contains the wrong effective date. The Division should consider the following revision:

~~[For]~~ Special Needs Trusts created on or after December 13, 201~~6~~ by an individual with a disability under age 65 for his or her own benefit can qualify as a special needs trust, conferring the same benefits as a special needs trust set up by a parent, grandparent, legal guardian or court.

Subject to correcting the above section, the Council may wish to consider endorsement since the initiative benefits individuals with disabilities and implements federal law.

11. DMMA Prop. DPBHS Targeted Case Management Regulation [21 DE Reg. 379 (11/1/17)]

The Division of Medicaid & Medical Assistance (DMMA) proposes to amend the Medicaid State Plan to add “targeted case management” as a covered service for DPBHS clients with qualifying mental health or substance abuse profiles.

Qualifying standards for youth are listed on p. 381 and should not be difficult to meet for anyone who meets the eligibility criteria for DPBHS services. Providers could be either DPBHS employees or employees of DPBHS contract agencies. At 383. Qualifications of “targeted case managers” and “highly qualified case managers” include degree, certification, training, and experience requirements. At 383-384. The scope of targeted case management services is very comprehensive and includes assessment, plan of care development and revision, coordination of meetings, referrals, and monitoring. At 382. Although DMMA projects no fiscal impact on DMMA, I suspect the State will “draw down” additional funds since the DPBHS has ostensibly been qualifying for Medicaid subsidies on a limited basis: “Currently, a limited amount of time is reimbursable through the DSCY&F Cost Allocation Plan, this will be discontinued and replaced with Targeted Case Management, at which the funds used to employ staff and contract with providers will be redirected to Targeted Case Management.” At 380.

I have the following observations.

First, the upper qualifying age limit is 18 which mirrors the general upper age limit of DPBHS services. See §A.2 on p. 381. However, the DSCY&F has discretion to extend foster care supports to individuals beyond age 18. Some of those covered individuals could have mental health and substance abuse needs being addressed by DPBHS. Therefore, DMMA could consider deleting the age limit and simply leaving in place the “qualifying for DPBHS services” requirement. As a practical matter, this will still generally limit eligibility to persons under age 18 while authorizing Medicaid-funded targeted case management services for a small subset of individuals served by the DSCY&F after age 18.

Second, there is a grammatical error in §D.1 on p. 382. It reads, in pertinent part, as follows:

The Targeted Case Manager will use a child and youth assessment tool designated by the Department or its designee to:

∴ To the initial assessment and to reassess at a minimum of every 3 months; ...

This makes no sense. The Division may wish to consider the following revision:

The Targeted Case Manager will use a child and youth assessment tool designated by the Department or its designee to:

∴ To ~~To~~ **[Prepare]** the initial assessment and to reassess at a minimum of every 3 months; ...

The Councils may wish to consider an endorsement of the initiative subject to consideration of the above revisions. A courtesy copy of comments could be shared with Steve Yeatman (DDC and DSCY&F) and Susan Cycyk (DPBHS Director).

12. DOE Proposed Visual Impairment Eligibility Regulation [21 DE Reg. 372 (11/1/17)]

The Delaware Department of Education proposes to amend its IDEA eligibility standards for visual impairment.

As background, OSEP published the attached Policy Letter to Kotler, 65 IDELR 21 (11/12/14) a few years ago which supported a broad view of “visual impairment” eligibility under the IDEA. For example, it repudiated language limiting eligibility to “severe” conditions:

(T)he definition of “visual impairment including blindness,” does not contain a vague modifier; rather, any impairment in vision, regardless of severity, is covered, provided that such impairment, even with correction, adversely affects a child’s educational performance.

At 2. In contrast, the Delaware eligibility standard for “visual impairment including blindness” was highly prescriptive and required a disease, condition or impairment of the eye or visual system that seriously affects visual function directly,...”. [emphasis supplied] See 21 DE Reg at 374.

On May 22, 2017 OSEP issued the attached guidance which reiterated and expanded upon the Kotler policy letter. OSEP repudiated state adoption of prescriptive criteria (e.g. “reduced visual field to 50 degrees or less” and encouraged states to conform inconsistent eligibility standards to the federal guidance.

On August 25, 2017 the Delaware DOE issued the attached policy letter directing districts and charter schools to use the federal regulatory definition of “visual impairment including blindness” pending formal adoption of a revised State regulation. The DOE is now promulgating the revised regulation.

I have the following observations.

First, the proposed definition is generally consistent with the federal guidance. However, it would be more informative to include an omitted reference. Compare the following:

Proposed DOE Regulation

6.17.2 This eligibility determination requires a thorough and rigorous evaluation with a data-based media assessment which is based on a range of learning modalities and includes a functional visual assessment.

Federal Guidance

When determining a child's vision status, the LEA's evaluation should be thorough and rigorous. Such evaluations should include a data-based media assessment, be based on a range of learning modalities (including auditory, tactile, and visual), and include a functional visual assessment.

The DOE may wish to insert "(including auditory, tactile, and visual)" in the State regulation for clarity.

Second, the DOE should promptly take steps to suspend and correct conflicting provisions in its November 5, 2015 MOU among the DOE, LEAs, charter schools, and DVI. For example, Section V literally states that eligibility to receive services from DVI is limited to students meeting the superseded DOE regulatory definition of "visual impairment including blindness". The "assessment" section could also be updated to conform to the new DOE regulation and OSEP guidance. The MOU is an important "working document" which, if not promptly revised, will predictably lead to confusion and violation of the IDEA.

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

13. DOE Prop. Prohibition of Discrimination Regulation [21 DE Reg. 364 (11/1/17)]

The Department of Education (DOE) proposes to repeal its current Prohibition of Discrimination regulation in its entirety and substitute a more detailed version. The DOE review and revision of the regulation was prompted by a July 17, 2017 directive from Governor Carney. At 364. While the new regulation is well intentioned, it is flawed.

I have the following observations.

First, the existing regulation bans discrimination "under any program or activity receiving approval or financial assistance from or through the Delaware Department of Education." [emphasis supplied] The proposed regulation eliminates this protection in favor of a myopic application of the anti-discrimination mandate exclusively to districts and charter schools. Consider the following effect of this approach:

A. The current regulation covers post secondary institutions and degree granting institutions of higher education which must be "approved" by the DOE. See 14 DE Admin Code 292. The proposed regulation omits higher education institutions.

B. The current regulation covers institutions and programs receiving financial assistance from or through the DOE. This includes a wide variety of entities, ranging from the University of Delaware's Center for Disabilities Studies to non-profits such as the Parent Information Center. See <https://aimdelaware.org/> See also 14 DE Admin Code 926.19.0 and <http://picofdel.org/services/educational-surrogate-parent-program.html>. Complementary federal law generally bars state educational agencies from providing financial assistance to entities which engage in discrimination. See, e.g., 34 C.F.R. 104.4(b)(v).

C. Department of Education internally approved or funded programs are literally subject to the current regulation. Thus, the Delaware Interscholastic Athletic Association is currently subject to the anti-discrimination mandate. See 14 Del.C. §303(a). The proposed regulation eliminates application of the anti-discrimination mandate to all DOE programs, including the DIAA. Likewise, the proposed regulation abrogates application of the anti-discrimination protection in the DOE's nonpublic school driver education program. See 14 Del.C. §127. Finally, all DOE scholarship programs would no longer be subject to the anti-discrimination regulation. Compare 14 Del.C. §3460 and 14 DE Admin Code 1200.

The Department should consider retaining the time-honored existing regulation and then including a more detailed supplement covering districts and charter schools.

Second, in the "purposes" section of the proposed regulation, the DOE asserts that it is banning discrimination not simply by entities receiving DOE approval or financial assistance, but any entity receiving "State of Delaware" approval or financial assistance. While this may have a salutary effect, the DOE's authority to ban discrimination in programs or activities approved or funded by other State agencies is questionable.

Third, the proposed regulation does not adequately address age-based considerations. For example, §6.1 recites as follows:

No Charter School or School District shall make available, sponsor or supervise any Extra-Curricular Activities that restrict student participation on the basis of Protected Characteristic(s).

Thus, a high school age student could demand the right to participate in an elementary school club or intermural team and vice versa. A three year old could apply to attend kindergarten. The DOE may wish to consider whether it intends to authorize such results.

Fourth, §9.0 requires schools to have informal and formal complaint procedures. As a practical matter, discrimination covered by the regulation will also constitute discrimination subject to other complaint resolution systems, including the U.S. DOE OCR complaint system. See <https://www2.ed.gov/about/offices/list/ocr/complaintprocess.html>. See also 14 DE Admin Code 258, 34 CFR 104.36, and 6 Del.C. Ch. 45. If schools solely provide notice of the complaint system in the regulation, families could easily be misled into believing this is their sole avenue of redress and miss a deadline. Moreover, 14 DE Admin Code 258 establishes a competing complaint system within public schools. For example, an LEP student may be aggrieved by a lack of language-based accommodations which could be the basis of a complaint under both the proposed regulation and DOE federal program complaint regulation (14 DE Admin Code 258.3.0). If the public school only provides a "Formal Student Complaint form" described in the proposed regulation, without notice of other complaint systems, this may be inherently misleading. The school would be directing the student to a less efficacious system since, in contrast to the DOE's federal program complaint procedure, it lacks an explicit right to appeal to the DOE and does not include a DOE investigation. The proposed regulation should include a "notice" provision identifying other grievance systems.

Fifth, the proposed regulation is silent on a student's right to appeal a district decision to the DOE. It's unclear if 14 Del.C. §1058 could be invoked to solicit State Board of Education review.

Sixth, in §9.1.2.3.2, the DOE should consider substituting "specify" for "specifies".

Seventh, in §11.0, first sentence, the DOE should consider substituting "at the beginning" or "by the beginning" for "for the beginning".

Eighth, in §12.0, the DOE should correct the reference to the "Individuals with Disabilities Education Act".

The Councils may wish to consider sharing the above observations with the DOE, SBE, and Attorney General.

14. DOE Proposed Accountability Regulation [21 DE Reg. 363 (11/1/17)]

The Department of Education is publishing a regulation comprehensively revamping its public school accountability regulations to align with its approved ESSA Plan. At 363. Given the length of the ESSA Plan (145 pages) and proposed regulation (15 pages), I have only had time to conduct a cursory review of the regulatory initiative.

I have the following observations.

First, overall, the regulatory scheme appears more "forgiving" than its predecessor. For example, "sanctions" are no longer contemplated. See proposed §1.1 and current §7.0. Language is also more euphemistic. For example, a parent would understand that a school characterized as a "Persistently Low Achieving School" is a school with chronic low performance. See, e.g., current §8.0. In contrast, the new "lowest" status is "Comprehensive Support and Improvement - Re-identified". Such a school has demonstrated chronically poor performance for at least six (6) years. See proposed §§7.1 and 7.2. The term is highly uninformative and could aptly be characterized as mumbo jumbo.

Second, proposed §2.4 cross references 14 DE Admin Code 101.9.0. That regulation has been "suspended" since FY08. The DOE may wish to revise the reference.

Third, the availability of disaggregated data is a valuable resource in "drilling down" to the source of performance deficits or high achievement. For example, one grade or one classroom in a school may be an outlier with either impressive performance or poor performance when compared to the school as a whole. Unfortunately, proposed §2.5 authorizes reporting only by whole schools and districts. Although §§ 2.62 and 2.6.3 refer to subgroup data, these sections do not literally authorize reporting of disaggregated data below the level of a school. It would be preferable to authorize reporting of data which is less "blunt" than composites of entire schools and districts.

Fourth, there is an error in proposed §2.6. The term “AYP” should include a ~~strikeout - “AYP”~~.

Fifth, proposed §4.3 should be reconsidered. It states as follows:

- 4.3. For accountability purposes, a student with a special exemption, as defined in 14 DE Admin Code 101, shall not be included in accountability calculations.

In contrast, 14 DE Admin Code 101 contains no “definition” of “special exemption” while directing the opposite result:

12.2.3.2. Students who are granted a special exemption shall be counted in the school participation rate for school and district accountability pursuant to 14 DE Admin Code 103.2.4.

There is also some “tension” between §4.3 (directing that exempt student results not be included in accountability calculations) and 14 Del.C. §1511.(j): “Students who are granted portfolio assessment under this subsection shall be included in the participation rate calculation for schools and school districts.”

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

15. Dept. of Insurance Proposed Health Ins. Arbitration Reg. [21 DE Reg. 406 (11/1/17)]

The SCPD and GACEC commented on an earlier version of this proposed regulation in September, 2017. A copy of the September 28, 2017 SCPD memorandum is attached for facilitated reference. The Department of Insurance is now publishing a revised proposed regulation incorporating some amendments prompted by the Councils’ commentary.

First, the Councils recommended that the Department of Justice not be limited to attorneys when providing assistance to persons appealing adverse health insurer substance abuse decisions. The Department agreed and revised the authorization to cover all forms of assistance (not merely legal assistance) and allow non-attorney assistance. At 407.

Second, the Councils recommended revising §2.0 to include “the DOJ website address (with description of its substance abuse legal assistance program) in addition to a phone number”. The Department agreed and added website and email addresses. Id.

Third, the Councils recommended incorporation of disclosure of the availability of DOJ assistance in notices required by the regulation. The Department compromised by incorporating disclosure in notices issued under the complementary regulation published at 21 DE Reg. 400 (11/1/17). Id.

Finally, the Department acknowledged the Councils’ endorsement of the original proposed regulation subject to considering the above amendments. Since the Department has improved the initiative consistent with the Councils’ earlier commentary, the Councils may wish to reiterate their endorsement without recommending any further changes.

16. Dept. of Insurance Proposed Health Ins. Claim Review Reg. [21 DE Reg. 400 (11/1/17)]

The SCPD and GACEC commented on an earlier version of this proposed regulation in September, 2017. A copy of the September 28, 2017 SCPD memorandum is attached for facilitated reference. The Department of Insurance is now publishing a revised proposed regulation incorporating some amendments prompted by the Councils' commentary.

First, the Councils recommended that the Department of Justice not be limited to attorneys when providing assistance to persons appealing adverse health insurer substance abuse decisions. The Department agreed and revised the authorization to cover all forms of assistance (not merely legal assistance) and allow non-attorney assistance. At 401.

Second, the Councils recommended revising §2.0 to include "the DOJ website address (with description of its substance abuse legal assistance program) in addition to a phone number". The Department agreed and added website and email addresses to multiple sections. Id.

Third, the Councils noted that the notice of availability of DOJ assistance was "buried in the boilerplate". The Councils recommended revisions to make the notice more prominent. The Department agreed and revised formatting and wording. Id.

Fourth, the Councils observed that the notice only disclosed the availability of DOJ assistance with mediation while omitting references in other review process regulatory sections. The Department agreed that DOJ assistance was not limited to mediation and added some conforming revisions. Id.

Fifth, the Councils observed that the notice in §4.0 could be misleading since it suggested that DOJ help would only be available if "you are approaching the deadline for filing your appeal". The Department omitted this language in the revised proposed regulation. Id.

Sixth, the Councils recommended revision of notices to highlight that DOJ assistance was "free". The Department observed that the enabling law is silent in this context and declined to add a reference clarifying that assistance is "free".

Finally, the Department acknowledged the Councils' endorsement of the original proposed regulation subject to considering the above amendments. Since the Department has significantly improved the initiative consistent with the Councils' earlier commentary, the Councils may wish to reiterate their endorsement without recommending any further changes.

Attachments

E:\legis\FY18\1117bils



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
Margaret M. O'Neill Bldg., Suite 1, Room 311
410 Federal Street
Dover, Delaware 19901
302-739-3621

The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: September 28, 2017

TO: Ms. Nicole Cunningham, DMMA
Planning & Policy Development Unit

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 21 DE Reg. 185 [DMMA Proposed Care Expense Deduction (9/1/17)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance (DMMA) proposes to amend the Medicaid State Plan to revise a countable income deduction. The proposed regulation was published as 20 DE Reg. 185 in the September 1, 2017 issue of the Register of Regulations.

As background, DMMA notes that the attached federal law [42 USC §1396(r)(1)(A)] authorizes states to deduct from countable income unreimbursed medical and remedial care expenses of a beneficiary receiving HCBS or institutional care. At 185. The Division is expanding the scope of the deduction from costs incurred within 30 days of the beginning date of Medicaid eligibility to 3 months of that date. At 187.

The projected fiscal impact is very modest, i.e., \$5,725 and 22,900 in State funds for FY17 and FY18 respectively. At 186.

The SCPD is endorsing the proposed regulation since the proposal benefits Medicaid enrollees receiving HCBS or institutional services with little fiscal impact.

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

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

21reg185 dmma care expense deduction 9-27-17

(r) DISREGARDING PAYMENTS FOR CERTAIN MEDICAL EXPENSES BY INSTITUTIONALIZED INDIVIDUALS

(1)

(A) For purposes of sections 1396a(a)(17) and 1396r-5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

(B)

(i) In the case of a veteran who does not have a spouse or a child, if the veteran—

(I) receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this subchapter, a veteran's pension in excess of \$90 per month, and

(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of title 38,

any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of \$90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home's cost of providing nursing home care to the veteran.

(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.

(2)

(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1396d(p) of this title may be less restrictive, and shall be no more restrictive, than the methodology—

(I) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under subchapter XVI, or

(II) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES

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The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: September 28, 2017

TO: Ms. Nicole Cunningham, DMMA
Planning & Policy Development Unit

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 21 DE Reg. 187 [DMMA Proposed "Psych Under 21" Reimbursement (9/1/17)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance (DMMA) proposal to amend its reimbursement methodology for inpatient psychiatric residential treatment facilities ("PRTFs"). DMMA notes (p. 188) that this benefit is often referenced as "Psych under 21". The proposed regulation was published as 20 DE Reg. 187 in the September 1, 2017 issue of the Register of Regulations.

As background, most states have elected to provide the "Psych under 21" optional benefit in their Medicaid plans. At 188. The benefit covers the costs of residential psychiatric services for individuals under age 21. Consistent with the attached CMS Bulletin, states have several options in establishing reimbursement rates. Some states have a single "bundled" per diem rate which covers all costs. Some states have a base per diem rate with add-on payments based on additional services which can be provided by non-facility professionals.

The current reimbursement standards are listed on pp. 189-190. DMMA posits that the revised standards will have no fiscal impact:

The proposed amendment imposes no increase in cost on the General Fund as the proposed services in this State plan amendment will be budget neutral. The federal fiscal impact associated with this amendment will be zero dollars.

At 189.

Delaware includes many services in the per diem rate, including dental services, OT, PT, ST, lab work, and transportation. In-state facilities are currently paid the lesser of (a) a facility's usual and customary charge; and (b) the standard per diem rate plus additional funds for services in the plan of care not in the

per diem rate. Out of state facilities are paid using the home state's per diem rate plus additional funds for services in the plan of care not in the per diem rate.

The SCPD has the following observations.

First, DMMA proposes to strike the current, discrete approach for out-of-state facilities. However, the proposed revision is not clear. I believe the Division intends to limit the following new third bullet on p. 189 to out-of-state facilities:

- The lesser of a negotiated per diem reimbursement rate, the facilities (sic "facility's) usual and customary charge, or the Delaware Medicaid per diem rate.

If that is the intent, DMMA should amend the provision as follows:

- If an out of state facility, ~~the~~ lesser of a negotiated per diem reimbursement rate, the facilities (sic "facility's) usual and customary charge, or the Delaware Medicaid per diem rate.

Otherwise, the first and second bullets are meaningless or superfluous and the "add on" for supplemental plan of care services in the first bullet would never be applicable. The new third bullet (with no "add on" authorization") would always be "lesser" than the first bullet.

Second, apart from inserting "(i)f in out of state facility", the Division should substitute "facility's" for "facilities" in both the second and new third bullets to correct the grammar.

Third, adopting the Delaware per diem reimbursement rate (as opposed to the home state reimbursement rate) should contribute to ease of administration, especially since a minority of states may have no "Psych under 21" rate. However, the deletion of the "add on" for "activities in the plan of care but not in the per diem" is not revenue neutral. Assuming the new third bullet only applies to out-of-state facilities, the deletion creates a lower reimbursement methodology for out-of-state facilities versus in-state facilities. DMMA may wish to consider amending the new third bullet to authorize an "add on" for "activities in the plan of care but not in the per diem".

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

cc: Ms. Susan Cycyk, DPBHS
Mr. John McKenna, Rockford Center
Mr. William Mason, Meadowood Hospital
Dr. Paul B. Rothman, Johns Hopkins Hospital
Ms. Carol Oliver, Devereux Behavioral Health
Mr. Steve Yeatman, DDC
Mr. Steve Groff, DMMA
Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

21reg187 dmna psych under 21 reimbursement 9-27-17



STATE OF DELAWARE
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The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: August 23, 2017

TO: Ms. Nicole Cunningham, DMMA
Planning & Policy Development Unit

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 21 DE Reg. 127 [DMMA Proposed DPAP Elimination (8/1/17)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposal to amend the regulations establishing the Delaware Prescription Drug Payment Assistance Program (DPAP). The proposed regulation was published as 21 DE Reg. 127 in the August 1, 2017 issue of the Register of Regulations.

The DPAP has historically been paid from the Delaware Health Fund (p. 128). The rationale (p. 128) is as follows:

The most recent internal Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) report indicates that all but two members have prescription coverage through Medicare Part D. The program is being eliminated due to a reduction in usage, along with an overall reduction in expenditures by DMMA.

The SCPD has the following observations.

First, the above justification is not very illuminating since most DPAP enrollees have had Medicare-D coverage in past years as well. DMMA notes (p. 128) that most costs for low-income Medicare-D beneficiaries are covered by Medicare -D:

Individuals with Medicare (the majority of DPAP clients) would select a Part D Prescription Plan and apply for Extra Help (Low-Income Subsidy) through the Social Security Administration. The Low-Income Subsidy, or LIS, which is paid by the Centers for Medicare & Medicaid Services, would provide financial assistance (at levels of 100%, 75%, 50%, and 25%) for monthly Part D premiums, annual deductibles, and prescription coverage through the Part D coverage gap to low-income individuals. Medicare Part D would be primary to the Delaware Prescription Assistance Program.

However, it would be informative to disclose what costs the DPAP covered which Medicare-D and the Low-Income Subsidy do not cover. For example, it is troubling to note that the FY17 Delaware Health Fund Advisory Committee approved \$2.5 million for this program which was included in the FY17 budget.¹ See attachments. In contrast, the FY18 budget (excerpt attached) omits any DPAP funding and the DHSS website (excerpt attached) indicates the program has already been eliminated. A reasonable person might ask what the \$2.5 million covered in FY17 that will not be covered in FY18.

Second, consistent with the attached excerpt from the Delaware Code, the enabling legislation for the DPAP has been repealed. Therefore, as a practical matter, the current regulation merely implements the repeal of the enabling law. However, the SCPD would like more information on the effect of the repeal, they could request the last few annual reports on the DPAP prepared in fulfillment of Title 16 Del.C. §3006B.

In summary:

1. The SCPD acknowledges the legislative repeal of the DPAP enabling law justifies the regulation;
2. The SCPD has concerns that the ramifications of the elimination of the program (which had a \$2.5 million appropriation in FY17) are not clear; and
3. The SCPD requests a copy of the last three annual reports prepared pursuant to the recently-repealed 16 Del.C. §3006B.

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

cc: Mr. Steve Groff, DMMA
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

21reg127 dmna-dpap elimination 8-23-17



Seniors face tough choices as state Rx program ends

MEREDITH NEWMAN
THE NEWS JOURNAL

Marilyn Townsend always envisioned paying for her own funeral.

The 87-year-old doesn't want anything elaborate. She plans on being cremated and having an obituary in the newspaper. She expects it will cost \$3,000.

Like her phone, rent, cable and grocery bills, Townsend wants to pay for it through her Social Security so her children don't have to.

The Clayton resident has been able to save money in recent months thanks to the Delaware Prescription Assistance Program, which helped cover prescription and over-the-counter drug costs for low-income Delaware seniors. It provided up to \$3,000 every year for people on the program.

But as of Thursday, it will no longer exist.

See PROGRAM, Page 5A

Program

Continued from Page 1A

And Townsend, like other Delawareans on the program, will have to re-evaluate what they can and cannot afford. Some say they will have to pay almost \$100 more a month.

"It maybe doesn't sound like much, but when you're 87 you should be able to do what you want to do," her daughter Carolyn said. "If these programs keep disappearing, nobody will have anything to fall back on."

The General Assembly eliminated the \$1.6 million program when it passed the budget on July 2, after missing the June 30 deadline for the first time in decades. Letters were sent to about 5,000 Delawareans shortly after informing them that, for the first time in years, the state will no longer help them pay for their premiums and prescriptions.

State health officials said the program was cut because the number of residents using it has tapered off in recent years and that by 2020 the program would no longer be needed.

But to the seniors who depended on the program, they say this is a blow to their already tight budgets. Some fear the residents, many of them Great Depression babies, will begin making sacrifices — such as rationing their medicine — in an effort to cut down new costs.

Residents who quali-



Master Pharmacy clerks Kerry Hoopes (left) and Shirley Wiggins work the cashier counter. SUSAN PEDERSON/THE NEWS JOURNAL

fied for the program had to be at least 65 years old or on Social Security; below 200 percent of the federal poverty level or have prescription costs that are at least 40 percent of their income; and not eligible for other prescription coverage through other state, federal or private programs.

Those on Medicare were required to select a Part D Prescription Drug Plan and apply for a low-income subsidy. This then covered Part D premiums, annual deductibles and prescription coverage.

Residents will now have to pay their Part D premiums starting in September.

About 5,300 people were actively enrolled in the program as of Decem-

ber 2015, according to the Delaware Prescription Assistance Program's 2016 Annual Report. This was a decrease from 6,088 in 2014.

The program itself cost the state about \$1.7 million down from almost \$1.9 million in 2014, according to the report.

Almost half of the Delawareans lived in Kent County, while 30.4 percent and 19.65 percent, respectively, lived in Sussex and New Castle counties.

The program was created in 2000 when the General Assembly passed a bill that established the Delaware Health Fund, which received money from the 1998 Master Settlement Agreement.

Major tobacco companies agreed in the settle-

ment to pay annual amounts to 46 states to compensate for the medical costs of caring for people with smoking-related illnesses.

The state also created the Delaware Health Fund Advisory Committee to make recommendations on how the money should be spent.

The Delaware Prescription Assistance Program was one of many programs to receive money from the health fund.

Despite the program being cut, the state still receives money from the tobacco settlement, said Jill Fredel, spokeswoman for Delaware Health and Social Services.

The committee will meet in the fall to determine spending recommendations for fiscal

year 2018, she said.

Fredel said Delaware was one of the last states in the country to eliminate a prescription assistance program.

More than half of the enrollees — 3,253 people — used between 1 cent to \$500 through the program in 2015. No one used all \$3,000, according to the report.

Steve Groff, the director of the Division of Medicaid and Medical Assistance, said the implementation of Medicare Part D in 2006 and the passing of the Affordable Care Act in 2010 led to a significant drop in the number of people who depend on the benefits.

The decision to eliminate the program has been in the works for the past year, he said.

Former Gov. Jack Markell included the elimination of the program in his budget in January and current Gov. John Carney kept it when the Legislature passed the budget this spring, Groff said.

"We're surprised, it came as a surprise," he said.

Kevin Musto, pharmacist and owner of Atlantic Apothecary in Smyrna, said he and other local independent pharmacists are concerned about how the program will hurt their clients.

For some seniors, there's a big difference between paying \$30 a month for prescriptions and paying \$5 a month. And getting a job at this stage in life isn't a viable option, he said.

These men and wom-

en have already paid their dues to society," Musto said. "When those vulnerable folks have to pay more money, they're going to go without something on their personal end. ... There are consequences."

And it's not always easy to find cheaper medication, he said. Some seniors are already on generic versions, while others have to take a certain brand because of a reaction.

Harold and Helen Masten, of Kenton, hoped to buy a new heater for their house this year.

But with the prescription program ending, they're now figuring out how to pay for their utilities.

"If we had to pay rent, we'd be in trouble," Harold said.

Helen, 89, gets three prescription eye drops to treat glaucoma, which cost her about \$25 through the Delaware Prescription Assistance Program.

Now, she said she has to pay about \$150 to cover the prescription and the Part D premium. She receives \$560 a month through Social Security.

Harold, 88, said he's disappointed with the General Assembly for making a decision that will change so much of their daily life.

"And ain't nothing we can do about it," he said.

Contact Meredith Newman at (302) 324-2386 or at mnewman@delawareonline.com. Follow her on Twitter at [@mnewman](https://twitter.com/mnewman).



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The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: August 29, 2017

TO: Ms. Nicole Cunningham, DMMA
Planning & Policy Development Unit

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 21 DE Reg. 124 [DMMA Proposed Medicaid Dental Fee Schedule (8/1/17)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposal to amend the Medicaid State Plan to reduce the reimbursement rate for child dental care. The Division recites that the current rate is "81.1% of commercial insurance charges". At 125. The Division proposes a 14% reduction in the rate, i.e., to approximately 69.75%. The proposed regulation was published as 21 DE Reg. 124 in the August 1, 2017 issue of the Register of Regulations.

The SCPD has the following observations.

First, there is ostensibly ample justification for the proposed rate reduction. DMMA notes that the 81.1% rate is the highest in the Nation based on a 2014 Health Policy Institute Policy Brief. The Health Policy Institute published a more recent Brief in April, 2017. A copy of the 2017 Brief is also attached. It corroborates that the Delaware Medicaid reimbursement rate is an "outlier" and exceeds that of all other states. See pp. 5-6.

Second, since the Medicaid reimbursement rate is based on a percentage of local commercial/insurance rates, the local commercial/insurance rates in Delaware are material in assessing the Medicaid rate. Delaware's commercial/private insurance child dental services rates rank 15th in the Nation. Id at p. 7. As a result, the new 69.75% rate would result in a higher reimbursement than application of the same rate in a state with a low commercial/insurance rate.

Third, as DMMA observes, the 14% rate reduction was incorporated into the State FY18 budget. At p. 125. Therefore, as a practical matter, it would be difficult to prompt reconsideration of the proposed Medicaid Plan amendment.

Fourth, it is instructive to assess the likely effect of the lower rate on access to services. Consistent with the attached access statistics for Delaware, New Jersey, Pennsylvania, and Maryland, the lower reimbursement rates in our sister states have not had any negative effect on access to dentists accepting Medicaid.

Fifth, DMMA projects a cost savings of \$2.6 million in state funds and \$4.1 million in federal funds in FY18. Therefore, while the State may save \$2.6 million, the value of this savings is undercut by the loss of \$4.1 million in federal dollars to the Delaware economy.

Sixth, the 2017 Brief (pp. 1-2) offers the following statistics:

A. Fifty-four percent (54%) of Medicaid-enrolled adults live in states that provide adult dental benefits in their Medicaid program.

B. Medicaid FFS reimbursement, on average, is 49.4 percent of fees charged by dentists for children and 37.2 percent for adults.

Thus, while Delaware is at the forefront in supporting child dental services, it is a laggard in supporting adult dental services. Since the average Medicaid reimbursement rates for adults nationwide (37.2%) is much lower than the rates for children (49.4%), it would be propitious if DMMA would assess prospects for devoting cost savings for children's dental services to adult coverage. The attached fiscal note on 2016 legislation (S.B. No. 142) to offer adult dental coverage was approximately \$7.3 million on an annualized basis. DMMA could assess the following financial options:

1) the effect of capping dental care assistance to an eligible recipient at \$500 instead of the \$1,000 contemplated by S.B. No. 142;

2) the effect of incorporating lower adult reimbursement rates into the fiscal note to reflect national norms; and

3) the effect of initially limiting the adult dental benefit to subpopulations (e.g. DDDS Lifespan Waiver enrollees).

The above options, alone or in combination, could facilitate adoption of an adult Medicaid benefit and potentially "draw down" millions of dollars in federal matching funds.

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

cc: The Honorable Bethany Hall-Long, Lt. Governor
Ms. Jill Rogers, DDDS
Mr. Steve Groff, DMMA
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

21reg124 dmma-medicaid dental fee schedule 8-23-17



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES

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The Honorable John Carney
Governor

John McNeal
SCPD Director

September 28, 2017

Ms. Susan K. Haberstroh, Education Associate
Department of Education
401 Federal Street, Suite 2
Dover, DE 19901

RE: 21 DE Reg. 176 [Proposed Foster Care Student Placement (9/1/17)]

Dear Ms. Haberstroh:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) proposed regulation to implement the attached S.B. No. 87 which was effective July 21, 2017. As the synopsis indicates, the legislation was motivated by changes in federal law. In a nutshell, students in the custody of DSCY&F are entitled to remain in their school of origin unless a decision is reached that such placement is not in the student's "best interest". The legislation requires the Department of Education to issue regulations defining the process for making the "best interest" determination. This proposed regulation was published as 20 DE Reg. 176 in the September 1, 2017 issue of the Register of Regulations.

The SCPD has the following observations.

First, the attached federal law [20 USC §6311] requires the "best interest" determination to specifically include consideration of "the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement." These considerations should be explicitly included in the DOE regulation,

Second, there is a major "disconnect" between the regulation and the enabling law. Although a principal impetus for S.B. No. 87 was ostensibly federal law addressing children in foster care, the bill is literally much broader in scope. It is not limited to children in foster care. The text of the bill never mentions foster care. Rather, the bill uniformly refers to "children in the custody of the Department of Services for Children, Youth and Their Families" and applies to any child covered by 13 Del.C. Ch. 25 (lines 11-12). That chapter never mentions foster care and broadly covers a broad range of children in DSCY&F custody. As a result, the title to the regulation ("Students in Foster Care") and all of the references to foster care are much narrower than the enabling law. The DOE was ostensibly under the impression that all students in DSCY&F custody are in foster care. Compare §§4.1.1 and 4.1.2 with §4.1.3. See also §2.0, definitions of "child in DSCY&F custody" and "student in foster care".

Third, the regulation categorically presumes that all children in DSCY&F custody are in DFS custody. Only DFS representatives are involved in the process established by the regulation and only a DFS caseworker is authorized to coordinate the scheduling of the Best Interest Meeting. See, e.g., §2.0, definitions of “DFS”, “DFS Caseworker”; §5.1; and §5.1.2. In fact, there may be no DFS caseworker involved with the child. The Family Court may grant custody of a child to any division of the DSCY&F. Compare Title 10 Del.C. §1009(b)(5) with §1009(b)(7). The DSCY&F Division of Prevention and Behavioral Health Services (DPBHS) may have sole custody of a child.

Fourth, the role of charter schools is unclear. There is a definition of “charter school” in §2.0. However, it is unclear if a charter school can be a “school of origin” (§3.0). A charter school is excluded from consideration as a “school of origin” under §3.1.3 (which refers to “Local School District”) but is not literally excluded from qualifying as a “school of origin” under §§3.1.1 and 3.1.2.

Fifth, the time period (10 working days) to notify the DOE of the inability to schedule a “Best Interest Meeting” is too long. See §4.2. A student covered by §4.1.3 may be receiving no or inappropriate services and the notice to DOE could be a simple email with attachments.

Sixth, the DOE should consider making the parent or educational representative one of the decision-makers at the Best Interest Meeting convened under §5.3. S.B. No. 52 (lines 52-54) indicates that the public representatives are “minimum”. The analogous federal law covering homeless youth prioritizes the views of the parent or unaccompanied youth:

(B) School stability. In determining the best interest of the child or youth under subparagraph (A), the local educational agency shall -

(i) presume that keeping the child or youth in the school of origin is in the child’s or youth’s best interest, except when doing so is contrary to the request of the child’s or youth’s parent or guardian, or (in the case of an unaccompanied youth) the youth;...

42 U.S.C. §11432(g)(3)

Seventh, the regulation does not provide notice of any appeal right. The analogous federal law covering homeless youth authorizes appeals. See 42 U.S.C. §§11432(g)(1) (C) and 11432(g)(3)(B)(E). If the placement decision can be appealed, the regulation should address notice of such right.

We expect that a high percentage of kids in DCYSF custody would be subject to IDEA or Section 504 for protection and therefore the placement decision would be effected protected by the regulations under those laws. Current regulation could be improved by addressing potential conflicts between the identified decision-making system and the decision-making system under 504 and the IDEA.

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

Sincerely,

Jamie Wolfe

Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

cc: The Honorable Susan S. Bunting, Ed.D., Secretary of Education
Mr. Chris Kenton, Professional Standards Board
Dr. Teri Quinn Gray, State Board of Education
Ms. Mary Ann Mieczkowski, Department of Education
Ms. 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

21reg176 doe foster care student placement 9-27-17

Excerpt

Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability

1. A Rule by the Centers for Medicare & Medicaid Services on 05/06/2016

For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in

2. 42 CFR part 438 contained in **42 CFR parts 430** to 481, edition revised as of October 1, 2015: §§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d), no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017. States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.

1. 11003.7.8 Special Needs

45 CFR 98.20

Eligibility

Families requesting Special Needs Child Care must be technically and financially eligible.

EXCEPTION: DFS referrals do not have to meet financial criteria.

The parent/caretaker must meet the need criteria as listed in 11003.8.

To be eligible for Special Needs care the parent/caretaker must meet the definition of need as explained below.

Adults with Special Needs:

A parent/caretaker may be eligible for Special Needs Child Care services if the parent/caretaker has a condition which makes him/her unable to care for his/her child for some portion of the day.

Documentation of the condition may be provided on the Special Needs Form or any other written correspondence submitted by a physician or medical professional with the authority to do so.

14 DE Reg. 1373 (06/01/11)

Children with Special Needs:

A child that is 13 through 18 years of age may be eligible for Special Needs Child Care if the child's parent/caretaker has a need and is financially eligible. The child's physical, medical or emotional condition must be such that the child is unable to care for himself or herself.

A child that is younger than 13 years of age who has a special need may be eligible for care if the child's parent/caretaker has a need and is financially eligible.

Documentation of the condition may be provided on the Special Needs Form or any other written correspondence submitted by a physician or medical professional with the authority to do so.

14 DE Reg. 1373 (06/01/11)

the requirement while minimizing any unnecessary burden on families. The final rule retains language in this provision as proposed in the NPRM.

Protective services. Section 658P(4) of the Act indicates that, for CCDF purposes, an eligible child includes a child who is receiving or needs to receive protective services. This final rule adds language at § 98.20(a)(3)(ii) to clarify that the protective services category may include specific populations of vulnerable children as identified by the Lead Agency. Children do not need to be formally involved with child protective services or the child welfare system in order to be considered eligible for CCDF assistance under this category. The Act references children who "need to receive protective services," demonstrating that the intent of this language was to provide services to at-risk children, not to limit this definition to serve children already in the child protective services system.

It is important to note that including additional categories of vulnerable children in the definition of protective services is only relevant for the purposes of CCDF eligibility and does not mean that those children should automatically be considered to be in official protective service situations for other programs or purposes. It is critical that policies be structured and implemented so these children are not identified as needing formal intervention by the CPS agency, except in cases where that is appropriate for reasons other than the inclusion of the child in the new categories of vulnerable child for purposes of CCDF eligibility. We received limited comments on this section and discuss these below.

Similarly, this final rule removes the requirement that case-by-case determinations of income and co-payment fees for this eligibility category must be made by, or in consultation with, a child protective services (CPS) worker. While consulting with a CPS worker is no longer a requirement, it is not prohibited; a Lead Agency may consult with or involve a CPS caseworker as appropriate. We encourage collaboration with the agency responsible for children in protective services, especially when a child also is receiving CCDF assistance.

These changes provide Lead Agencies with additional flexibility to offer services to those who have the greatest need, including high-risk populations, and reduce the burden associated with eligibility determinations for vulnerable families.

Under previous regulations at § 98.20(a)(3)(ii)(B), at the option of the Lead Agency, this category could already include children in foster care. The regulations already allowed that children deemed eligible based on protective services may reside with a guardian or other person standing "in loco parentis" and that person is not required to be working or attending job training or education activities in order for the child to be eligible. In addition, the prior regulations already allowed grantees to waive income eligibility and co-payment requirements as determined necessary on a case-by-case basis, by, or in consultation with, an appropriate protective services worker for children in this eligibility category. This final rule clarifies, for example, that a family living in a homeless shelter may not meet certain eligibility requirements (e.g., work or income requirements), but, because the child is in a vulnerable situation, could be considered eligible and benefit from access to high-quality child care services.

We note that this new provision does not require Lead Agencies to expand their definition of protective services. It merely provides the option to include other high-needs populations in the protective services category solely for purposes of CCDF, as many Lead Agencies already choose to do.

We did not receive many comments on this policy, but those who did comment were supportive of this clarification and appreciative of the "discretion to include specific populations of vulnerable children, especially if they do not need to be formally involved with CPS or child welfare system." The regulatory language proposed in the NPRM is retained in this final rule.

Additional eligibility criteria. Under pre-existing regulations, Lead Agencies are allowed to establish eligibility conditions or priority rules in addition to those specified through Federal regulation so long as they do not discriminate, limit parental rights, or violate priority requirements (these are described in full at § 98.20(b)). This final rule revises this section in paragraph 98.20(b)(4) to add that any additional eligibility conditions or priority rules established by the Lead Agency cannot impact eligibility other than at the time of eligibility determination or re-determination. This revision was made to be consistent with the aforementioned change to § 98.20(a) which says that eligibility criteria apply only at the time of determination or re-determination. It follows that the same would be true of additional criteria established at the Lead Agency's option.

The final rule adds paragraph (c), clarifying that only the citizenship and immigration status of the child, the primary beneficiary of CCDF, is relevant for the purposes of determining eligibility under PRWORA and that a Lead Agency, or other administering agency, may not condition eligibility based upon the citizenship or immigration status of the child's parent. Under title IV of PRWORA, CCDF is considered a program providing Federal public benefits and thus is subject to requirements to verify citizenship and immigration status of beneficiaries. In 1998, ACF issued a Program Instruction (ACYF-PI-CC-98-08) which established that "only the citizenship status of the child, who is the primary beneficiary of the child care benefit, is relevant for eligibility purposes." This proposal codifies this policy in regulation and clarifies that Lead Agencies are prohibited from considering the parent's citizenship and immigration status.

ACF has previously clarified through a program instruction (ACYF-PI-CC-98-09) that when a child receives Early Head Start or Head Start services that are supported by CCDF funds and subject to the Head Start Performance Standards, the PRWORA verification requirements do not apply. Verification requirements also do not apply to child care settings that are subject to public educational standards. These policies remain in effect.

All comments received were supportive of the clarification on citizenship and this policy will remain in this final rule. One national organization commented that "ensuring that the citizenship or immigration status of a child's parent does not impact their ability to access CCDF-funded child care maintains the program's focus on ensuring access to high-quality child care services for vulnerable populations. Given that this policy was previously contained in sub-regulatory guidance to States, we are very appreciative of ACF's proposal to codify it within the CCDF program regulations."

§ 98.21 Eligibility Determination Processes

In this final rule, § 98.21 addresses the processes by which Lead Agencies determine and re-determine a child's eligibility for services. In response to comment, this final rule includes a new § 98.21(a)(5) which describes limited additional circumstances for which assistance may be terminated prior to the end of the minimum 12-month eligibility period, which will be discussed in greater detail below.

Minimum 12-month eligibility.

Section 98.21 reiterates the statutory change made in Section 658E(c)(2)(N)(i) of the Act, which establishes minimum 12-month eligibility periods for all CCDF families, regardless of changes in income (as long as income does not exceed the Federal threshold of 85 percent of SMI) or temporary changes in participation in work, training, or education activities. Under the Act, Lead Agencies may not terminate CCDF assistance during the 12-month period if a family has an increase in income that exceeds the Lead Agency's income eligibility threshold but not the Federal threshold, or if a parent has a temporary change in work, education or training.

We note that, during the minimum 12-month eligibility period, Lead Agencies may not end or suspend child care authorizations or provider payments due to a temporary change in a parent's work, training, or education status. In other words, once determined eligible, children are expected to receive a minimum of 12 months of child care services, unless family income rises above 85% of SMI or, at Lead Agency option, the family experiences a non-temporary cessation of work, education, or training.

As the statutory language states that a child determined eligible will not only be considered to meet all eligibility requirements, but also "will receive such assistance," Lead Agencies may not offer authorization periods shorter than 12 months as that would functionally undermine the statutory intent that, barring limited circumstances, eligible children shall receive a minimum of 12 months of CCDF assistance. We note that, despite the language that the child "will receive such assistance," the receipt of such services remains at the option of the family. The Act does not require the family to continue receiving services nor does it force the family to remain with a provider if the family no longer chooses to receive such services. Lead Agencies would not be responsible for paying for care that is no longer being utilized. This is discussed further in the new § 98.21(a)(5).

Comment: Comments were generally supportive of the statutory change to a minimum 12-month eligibility period, though there were concerns about the costs and possible impacts on enrollment patterns. Those in support emphasized that this change "would make it easier for families to access and retain more stable child care assistance and increase continuity of care for children." These commenters considered this a significant improvement to the previous law which

"commonly resulted in children experiencing short periods of assistance of usually less than a year, and families cycling on and off assistance," and had the unintended consequence of "modest increases in earnings or brief periods of unemployment or reductions in work hours caus[ing] families to lose child care assistance."

Other commenters also thought that "setting eligibility for longer periods will dramatically reduce the significant administrative burden on small businesses and at-risk families," and that this policy will facilitate "the ability to partner with others such as Head Start and Early Head Start and increases the quality of those partnerships."

However, some commenters, particularly States, shared concerns about the implications of this change, wanting to "draw attention to the significant cost of this requirement especially in light of stagnant funding levels to implement all the required changes." Another commenter focused on the idea that the "unintended consequence of these proposed rules is that by extending eligibility for current recipients of child care subsidies, other families in need will never have a chance to access the subsidies because federal funding has not been sufficiently increased to cover the cost."

Response: While we recognize the logistical challenges that States will experience as they are transitioning to minimum 12-month eligibility, we re-emphasize that this is a statutory requirement. We also think these longer periods of assistance will ensure that families derive greater benefit from the assistance and that this policy creates more opportunity for families to work towards economic stability. Any policy decision will have significant tradeoffs, and while the total number of families served may decrease as families stay on longer, this effect would be due to a decrease in churn, meaning that the number of children and families served at any given point would not be affected by families staying on longer. We think that the added benefit of continuity of services provided by reducing churn will have a positive overall impact on children and families and be a more effective use of federal dollars.

However, we do recognize that during the minimum 12-month redetermination periods, it may be necessary to collect some information to complete the redetermination process in time. We allow such practices, so long as it is limited (e.g. a few days or weeks in advance) and is not used as a way to circumvent the minimum 12-month period. Even if information is collected

in advance, eligibility cannot be terminated prior to the minimum 12-month period, even if disqualifying information is discovered during the preliminary collection of documentation (unless it indicates that family income has exceeded 85% of SMI or, at the Lead Agency option, the family has experienced a non-temporary cessation in work, or attendance at a training or education program).

Comment: One commenter questioned our interpretation of the Act that "assistance must be at the same level throughout the period." This commenter thought that "a State should be able to adjust the number of authorized hours (and thus the payment level) within the 12-month period due to a change in the number of hours of child care needed for a parent to work or participate in education or training, while maintaining eligibility for the entire 12-month period."

Response: Section 658E(c)(2)(N)(i)(I) of the Act states that each child who receives assistance under this subchapter in the State will be considered to meet all eligibility requirements for such assistance "and will receive such assistance" for not less than 12 months before the State or designated local entity re-determines the eligibility of the child under this subchapter. "[A]nd will receive such assistance" clearly indicates that eligibility and authorization for services, as determined at the time of eligibility determination or redetermination, should be consistent throughout the period. To clarify the regulatory language on this policy, we are adding language at § 98.21(a)(1) to say that once deemed eligible, the child shall receive services "at least at the same level" for the duration of the eligibility period. This also makes this section more consistent with the Act, which says that the child will receive such assistance, for not less than 12 months, and § 98.21(a)(3) of the final rule, which prohibits Lead Agencies from increasing family co-payments within the minimum 12-month eligibility period.

We are making a change to the language as proposed in the NPRM to now say that, once deemed eligible, the child shall receive services "at least at the same level." This makes it clear that the Lead Agency still has the ability to increase the child's benefit during the eligibility period, aligning the section with the provision at § 98.21(e)(4)(i), which requires Lead Agencies to act on information provided by the family if it would reduce the family's co-payment or increase the family's subsidy.

However, we do note that a State is not obligated to pay for services that are

not being used, so if a family voluntarily changes their care arrangement to use less care, the State can adjust their payments accordingly. We do want to reemphasize, however, that as this rule makes it clear that authorizations do not have to be tied to a family's work, training, or education schedule, even if the parents' schedule changes, in the interest of child development and continuity, the child must be allowed the option to stay with their care arrangement.

Definition of temporary: This final rule defines "temporary change" at § 98.21(a)(1)(ii) to include, at a minimum: (1) Any time-limited absence from work for employed parents due to reasons such as need to care for a family member or an illness; (2) any interruption in work for a seasonal worker who is not working between regular industry work seasons; (3) any student holiday or break for a parent participating in training or education; (4) any reduction in work, training or education hours, as long as the parent is still working or attending training or education; and (5) any cessation of work or attendance at a training or education program that does not exceed three months or a longer period of time established by the Lead Agency.

The above circumstances represent temporary changes to the parents' schedule or conditions of employment, but do not constitute permanent changes to the parents' status as being employed or attending a job training or educational program. This definition is in line with Congressional intent to stabilize assistance for working families. Lead Agencies must consider all changes on this list to be temporary, but should not be limited by this definition and may consider additional changes to be temporary. The final rule modifies language proposed in the NPRM at § 98.21(a)(1)(ii)(A), which addresses absences from employment. Whereas the NPRM stipulated that the definition of temporary had to include family leave (including parental leave) or sick leave, the final rule modifies this to say any time-limited absence from work for an employed parent due to reasons such as need to care for a family member or an illness. This change was made to acknowledge that while a parent may have a legitimate reason for an absence, there may be circumstances where leave is not granted by the employer. This language ensures that even if official leave has not been granted, CCDF assistance should still be continued. To clarify, in this new language still accounts for family leave (or parental leave), which will now be included

under the need to care for a family member.

Section 98.21(a)(ii)(F) clarifies that a child must retain eligibility despite any change in age, including turning 13 years old during the eligibility period. This is consistent with the statutory requirement that a child shall be considered to meet all eligibility requirements until the next re-determination. This allows Lead Agencies to avoid terminating access to CCDF assistance immediately upon a child's 13th birthday in a manner that may be detrimental to positive youth development and academic success or that might abruptly put the child at-risk if a parent cannot be with the child before or after school.

Comment: Commenters were supportive of this clarification, one stating that "taken together, these provisions protect children from losing access to child care because their parent experiences a temporary change in employment status, small increase in income, or has to move within the State," and another commenter stated that they found it particularly helpful "that ACF declares eligibility is maintained when a parent is using sick leave or parental leave or is on a student holiday break from classes."

However, one comment indicated that the State "would incur significant costs if allowed children to stay on after they turn 13," and recommended "State discretion to do this pending available funds."

Response: Given that there were few comments opposing this new policy allowing children to remain eligible after they turn 13, we are keeping this provision in this final rule. Additionally, given the nature of funding for CCDF, this "significant cost" is more accurately characterized as a reallocation of expenses rather than new costs. For the small subset of CCDF children who will turn 13 during their eligibility period, there is value in allowing them to retain eligibility, and that the benefits of such policies outweigh the potential challenges. We also note that if the family chooses to stop utilizing care prior to the end of the eligibility period (e.g. the school year ends and there are no plans for care during the summer), then the State would no longer be obligated to pay for the care that is not being used.

At § 98.21(a)(ii)(G), this final rule requires that a child retain eligibility despite any change in residency within the State, Territory, or Tribal service area. This provides stability for families who, under current practice, may lose child care assistance despite maintaining their State, Territory or

Tribal residency. This may require coordination between localities within States, Territories, or Tribes or necessitate some Lead Agencies to change practices for allocating funding. This level of coordination is essential, as the State, Territory, or Tribe is the entity responsible for CCDF assistance.

Comment: We received a number of comments in this area, some that were supportive of this policy and its importance for ensuring that families retain their benefits, and others, particularly States that are county-administered, that were concerned about the implementation of this requirement. A number of States indicated that "due to the unique administrative structure of [county administered] States, with delegated authority to local entities for administration of programs and services, the transference of eligibility, from one part of the State to another, poses uniquely difficult situations when each locality has a distinctive financial situation. For example, the States are unsure how to handle continuity of services and maintenance of 12-month eligibility during situations where a family moves out of the county where they initially became eligible and into a county that is out of funding and has a wait list." Some commenters asked for further clarification, particularly as it related to which county would be responsible for the ongoing payment, "If a child is eligible for 12 months, does the originating county continue payments or the receiving county? Or, should the State reserve funding to address the inter-county movement of families?" This commenter further emphasized that "given the financial impact, additional guidance is needed with regard to how 12-month eligibility is funded."

This also raised the issue of what happens when a family moves out of State. One commenter said, "There are also situations where a customer moves out of State. In some instances, they move without notifying the Lead Agency. [This] Lead Agency recommends that the rule is amended to allow Lead Agencies to terminate benefits prior to 12-months if it is discovered that a family moved out of State."

Response: Given the number of comments on this issue, we carefully considered the various factors in play and are keeping the policy on retaining eligibility if a family moves within the State, but are adding new language that would allow a Lead Agency to terminate eligibility prior to the end of the eligibility period if the family moves out of the State.

While we understand some of the unique challenges facing county-administered States, given that the CCDF block grant is a block grant to the State, it is reasonable for the State to develop policies that allow a family to retain their eligibility as long as they remain within the State. The question of whether the receiving or originating county should pay for the assistance is a question best left up to the State. These are logistical and implementation issues that will vary depending on each State's approach to administering the program. However, we do emphasize that this does not prohibit counties from establishing different eligibility criteria to take into account local variation.

As for a family that moves out of the State, we agree that this would be considered appropriate grounds for termination. We have added a new section at § 98.21(a)(5) describing additional limited circumstances that would allow a Lead Agency to end assistance prior to the end of the minimum 12-month eligibility period. We discuss this in more detail below, but the new regulatory language at § 98.21(a)(5)(ii) allows Lead Agencies to terminate assistance due to a change in residency outside of the State, Territory, or Tribal service area. However, while the final rule allows Lead Agencies to terminate for this reason, this is a permissive policy and not a requirement. Neighboring States/Territories/Tribes can still develop agreements to allow families to retain their eligibility if they cross State/Territory/Tribal boundaries. For example, in large metropolitan areas where daily commutes and neighborhoods regularly cross State boundaries, or Tribal populations which may move outside the Tribal service area but remain within a State boundary, it may be appropriate to develop such agreements. We encourage Lead Agencies to develop policies to meet the needs of their families and match the realities of their population's geographic and economic mobility.

Nothing in this rule prohibits Lead Agencies from establishing eligibility periods longer than 12 months or lengthening eligibility periods prior to a re-determination. We encourage (but do not require) Lead Agencies to consider how they can use this flexibility to align CCDF eligibility policies with other programs serving low-income families, including Head Start, Early Head Start, Medicaid, or SNAP. For example, once determined eligible, children in Head Start remain eligible until the end of the succeeding program year. Children in Early Head Start are considered eligible until they age out of the program.

Consistent with existing ACF guidance (ACYF-PIQ-CC-99-02) a Lead Agency could establish eligibility periods longer than 12 months for children enrolled in Head Start and receiving CCDF in order to align eligibility periods between programs. Similarly, Lead Agencies are encouraged to establish longer eligibility periods during an infant or toddler's enrollment in Early Head Start or in other collaborative models, such as Early Head Start-Child Care Partnerships.

Operationalizing alignment across programs can be challenging, particularly if families enroll in programs at different times. While the Lead Agency must ensure that eligibility is not re-determined prior to 12 months, it could align with other benefit programs by "resetting the clock" on the eligibility period to extend the child's CCDF eligibility by starting a new 12-month period if the Lead Agency receives information, such as information pursuant to eligibility determinations or re-certifications in other programs, that confirms the child's eligibility and current co-payment rate. Alignment promotes conformity across Federal programs, such as SNAP, and can simplify eligibility and reporting processes for families and administering agencies. However, it should be noted that a Lead Agency cannot terminate assistance for a child prior to the end of the minimum 12-month period if the recertification process of another program reveals a change in the family's circumstances, unless those changes impact CCDF eligibility (e.g., a change in income over 85 percent of SMI or, at the option of the Lead Agency, a non-temporary change in the work, job training, or educational status of the parent). We retained the language in section 98.21(a)(1) as proposed in the NPRM.

Continued assistance. In 98.21(a)(2) of this final rule, if a parent experiences a non-temporary job loss or cessation of education or training, Lead Agencies have the option—but are not required—to terminate assistance prior to the minimum 12 months. Per the Act, prior to terminating assistance, the Lead Agency must provide a period of continued assistance of at least three months to allow parents to engage in job search activities. By the end of the minimum three-month period of continued assistance, if the parent is engaged in an eligible work, education, or training activity, assistance should not be terminated and the child should either continue receiving assistance until the next scheduled re-determination or be re-determined eligible for an additional minimum 12-

month period. This final rule clarifies that assistance must be provided at least at the same level during the period. This clarification is important because reducing levels of assistance during this period would undermine the statutory intent to provide stability for families during times of increased need or transition.

It is important to note that the Act allows Lead Agencies to continue child care assistance for the full minimum 12-month eligibility period even if the parent experiences a non-temporary job loss or cessation of education or training. The default policy is that a child remains eligible for the full minimum 12-month eligibility period, but the Lead Agency has the option to terminate assistance under these particular conditions. A Lead Agency may choose not to terminate assistance for any families prior to a re-determination at 12 months.

If a Lead Agency chooses to terminate assistance under these conditions after at least three months of continued assistance, it has the option of doing so for all CCDF families or for only a subset of CCDF families. For example, a Lead Agency could choose to allow priority families (e.g., children with special needs, children experiencing homelessness) to remain eligible through their eligibility period despite a parent's loss of work or cessation of attendance at a job training or educational program, but terminate assistance (after a period of continued assistance) for families who do not fall in a priority category. Or, a Lead Agency may choose to allow families in certain types of care, such as high-quality care, to remain eligible regardless of a parent's work or education activity.

While the Lead Agency must provide continued assistance for at least three months, there is no requirement to document that the parent is engaged in a job search or other activity related to resuming attendance in an education or training program during that time. In fact, we strongly discourage such policies as they would be an additional burden on families and be inconsistent with the purposes of CCDF.

If a Lead Agency does choose to terminate assistance under these circumstances, it must allow families that have been terminated to reapply as soon as they are eligible again instead of making the family wait until their original eligibility period would have ended in order to reapply.

A policy that provides continuous eligibility, regardless of non-temporary changes, reduces the burden on families and the administrative burden on Lead Agencies by minimizing reporting and

the frequency of eligibility adjustments. Retention of eligibility during periods of family instability (such as losing a job) can alleviate some of the stress on families, facilitate a smoother transition back into the workforce, and support children's development by maintaining continuity in their child care. Moreover, studies show that the same families that leave CCDF often return to the program after short periods of ineligibility. A report published by the Assistant Secretary for Planning and Evaluation (ASPE) at HHS, *Child Care Subsidy Duration and Caseload Dynamics: A Multi-State Examination*, found that "many families receive subsidies sporadically over time and frequently return to the subsidy programs after they exit." Short periods of subsidy receipt can be the result of a variety of factors, including eligibility policies and procedures. The "churning" present in CCDF demonstrates that families often lose their child care assistance for conditions that are temporary, which is detrimental for the family and child and inefficient for the Lead Agency.

Lead Agencies considering the option to terminate assistance in response to "non-temporary" changes are encouraged to use administrative data to understand the extent to which CCDF families currently cycle on and off the program, to make a determination as to whether it is in the interest of anyone (child, parent, or agency) to terminate assistance for families who may ultimately return to the program.

Some Lead Agencies include in their definition of allowable work activities a period of job search and allow children to initially qualify for CCDF assistance based on their parent(s) seeking employment. It is not our intention to discourage Lead Agencies from allowing job search activities as qualifying work. Therefore, consistent with language included in the preamble to the NPRM, new regulatory language at § 98.21(a)(2)(iii) addresses this circumstance. This is consistent with the intent of the Act to allow Lead Agencies the option to end assistance prior to a re-determination if the parent(s) has not secured employment or educational or job training activities, as long as assistance has been provided for no less than three months. In other words, if a child qualifies for child care assistance based on a parent's job search, the Lead Agency has the option to end assistance after a minimum of three months if the parent has still not found employment, although assistance must continue if the parent becomes employed during the job search period. Even if the parent does not find employment within three

months, Lead Agencies could choose to provide additional months of job search to families as well or to continue assistance for the full minimum 12-month eligibility period.

Comment: Commenters were supportive of this policy. One State indicated while "continuity will have a fiscal impact," they thought that "allowing States the option to terminate assistance prior to 12 months, with a minimum of 3 months of continued assistance is reasonable." Other States voiced appreciation for the clarification that States have the "discretion to continue assistance to a subset of families such as those within a certain priority or type of care."

There was a request for clarification regarding how often the minimum 3-month period of continued assistance could apply within a particular eligibility period. The commenter asked "if, within the 12-month eligibility period, an individual experiences more than one occasion of permanent job loss or of education/training, do they continue to get 3 months of job search each time, and with each new loss?" These commenters asked for clarification about "whether there are any limitations to how many times within a single 12-month eligibility period a person is entitled to a 3-month job search period." This was raised as a concern because of the potential negative impact it could have on a parent's motivation "to truly reestablish employment or education if they are able to "work" for one day every three months and still continue to receive services."

Response: A plain reading of the statutory language does not provide a limit to the number of times a family could receive the period of continued assistance. Given that the 3-month period of continued assistance is at the State option and that the default policy (as stated above) is for families to retain their eligibility until the end of the eligibility period, it would be inconsistent to put a limit on how many times this could apply. Since the intent of this provision is to allow the parent some time to resume work, or resume attendance at a job training or educational activity, a parent who has successfully found new employment or resumed another qualifying activity within the minimum 3-month period should not be penalized by losing their child care assistance (and possibly undermining the stability of newfound employment, training, or education). Especially given the often unstable nature of employment among low-income communities, this will provide some measure of stability in instances

where families, despite their best efforts, cycle in and out of employment. In these instances, when the home life may be in flux, a level of stability in the child's care arrangement becomes that much more valuable.

Additional circumstances for termination: In the proposed rule, we asked for comment on whether there are any additional circumstances other than those discussed above under which a Lead Agency should be allowed to end a child's assistance (after providing three months of continued assistance) prior to the minimum 12-month period. Commenters were reminded that since these regulations must comply with statutory requirements, any suggestions had to remain within the bounds of the Act in order to be considered.

Based on feedback from States and various stakeholders (received prior to the publication of the proposed rule), ACF had already considered possible exceptions to the minimum 12-month eligibility period for certain populations, such as children in families receiving TANF and children in protective services, but had decided that such special considerations would be in conflict with the Act, which clearly provides 12-month eligibility for all children.

Comment: We had a number of comments in this area. Commenters provided suggestions for reasons that a State should be able to terminate assistance prior to the end of the eligibility period, including: Non-use of subsidy, fraud or intentional program violations, moving out of the State, changes in household composition, protective services status (some emergency assistance that may not be required for a full eligibility period), change in priority group, and failure to cooperate with mandatory child support.

Response: We agreed with commenters on the need to provide some additional allowances in this area because there were legitimate reasons why a Lead Agency may need to terminate assistance prior to the end of the eligibility period. Therefore, in response to comments, the final rule adds a new § 98.21(a)(5), which describes additional limited circumstances that would allow a Lead Agency to end assistance prior to the end of the minimum 12-month eligibility period.

This new regulatory language states that notwithstanding paragraph (a)(1), the Lead Agency may discontinue assistance prior to the next re-determination in limited circumstances where there have been: (i) Excessive unexplained absences despite multiple

attempts by the Lead Agency or designated entity to contact the family and provider, including notification of possible discontinuation of assistance; (A) If the Lead Agency chooses this option, it shall define the number of unexplained absences that shall be considered excessive; (ii) A change in residency outside of the State, Territory, or Tribal service area; or (iii) Substantiated fraud or intentional program violations that invalidate prior determinations of eligibility.

We have determined that these three were compelling reasons for which Lead Agencies would be justified in acting. Regarding termination due to excessive unexplained absences, we stress that every effort should be made to contact the family prior to terminating benefits. Such efforts should be made by the Lead Agency or designated entity, which may include coordinated efforts with the provider to contact the family. If a State chooses to terminate for this reason, the Lead Agency must define how many unexplained absences would constitute an "excessive" amount and therefore grounds for early termination. The definition of excessive should not be used as a mechanism for prematurely terminating eligibility and must be sufficient to allow for a reasonable number of absences. It is ACF's view that unexplained absences should account for at least 15 percent of a child's planned attendance before such absences are considered excessive. This 15 percent aligns generally with Head Start's attendance policy and ACF will consider it as a benchmark when reviewing and monitoring this requirement.

As discussed above, we are allowing States to terminate eligibility if the family moves outside of the State, Territory, or Tribal service area. This was not explicitly discussed in the proposed rule, but the discussion about maintaining eligibility when moving within State revealed the need for clarification in this area. Given that the CCDF program is a block grant with the State, it would not make sense for the family's benefit to be able to travel across those borders. As discussed above, this is a permissive policy and not a requirement. We encourage Lead Agencies to develop agreements where appropriate to accommodate parental movement, particularly in areas where appropriate and necessary to meet the needs of families. And as a reminder, as stated in § 98.21(a)(ii)(G), States cannot terminate assistance if a family is moving within the State.

As for changes in household composition, this is already allowed, in so far as the Lead Agency can require

families to report such changes if they would result in a change that would raise the family's income level above 85% of SMI.

Fraud or intentional program violation would also be a legitimate reason to terminate assistance if such fraud invalidates the prior eligibility determination or redetermination. One commenter stated that it "is critical to have processes and procedures in place to limit improper payments and other fraudulent activities," and therefore recommended including a provision in the final rule that families could lose eligibility if they misrepresented circumstances at the initial determination and/or provided fraudulent information. Early termination of benefits is justified when there has been substantiated fraud or intentional program violation and such a family would not have been eligible. We caution that this does not change the limitations on what a State can require a family to report during the eligibility period. However, in instances where program integrity efforts reveal fraud or intentional program violations, under this final rule, the State would be able to terminate eligibility.

Co-payments. Section 98.21(a)(3) clarifies that a Lead Agency cannot increase family co-payment amounts within the minimum 12-month eligibility period as raising co-payments within the eligibility period would not be consistent with the statutory requirement that the child receive such assistance for not less than 12 months. Protecting co-payments levels within the eligibility period provides stability for families and reduces administrative burden for Lead Agencies. This final rule includes an exception to this rule for families that are eligible as part of the graduated phase-out provision discussed below.

In addition, the final rule requires the Lead Agency to allow families the option to report changes, particularly because we want to permit families to report those changes that could be beneficial to the family's co-payment or subsidy level. The Lead Agency must act upon such reported changes if doing so would reduce the family's co-payment or increase the subsidy. The Lead Agency is prohibited from acting on the family's self-reported changes if it would reduce the family's benefit, such as increasing the co-payment or decreasing the subsidy.

The limitation on raising co-payments, by protecting the child's benefit level for the minimum 12-month eligibility period, is consistent with the statutory requirement at 658E(c)(2)(N) of the Act that, once deemed eligible, a

child shall receive such assistance, for not less than 12 months. Raising co-payments earlier than the 12-month period could potentially destabilize the child's access to assistance and has the unintended consequence of forcing working parents to choose between advancing in the workplace and child care assistance. This is discussed further below in the section on reporting changes in circumstances.

Comment: Comments received in this area were mixed. In general, States wanted to retain the ability to increase co-payments throughout the year, while national organizations and other stakeholders thought that keeping co-payments stable during the year was a worthwhile policy for families.

Those who supported this policy cited studies that showed that "high co-payments are a major reason that families leave the subsidy program." Commenters also referenced a Senate Health, Education, Labor, and Pensions Committee Report on the CCDBG Act, which notes that "The committee does not want to discourage families engaged in work from pursuing greater opportunities in the form of increased wages or earnings. . . . The committee strongly believes that if families are truly to achieve self-sufficiency that CCDBG cannot perversely incentivize families to forgo modest raises or bonuses for fear of losing assistance under the CCDBG program."

Those in favor of retaining the ability to increase co-pays pointed to the implications, primarily financial, should they be unable to adjust co-payments. One stated that they would be forced to "charge the highest co-payment amounts allowed in order to manage the fiscal liability" and another pointed out that such a policy "limits the Department's ability to utilize co-payments as a means of managing State fiscal resources," and an inability to do so would "result in serving fewer children and families and may force waitlists."

Other commenters stated that they thought increasing co-payment amounts during the eligibility period would not negatively affect a family's subsidy or co-payment and would not be unduly burdensome. This commenter reasoned that "In most cases, income changes reported are fairly small, and even if that change moves the family up on the co-pay schedule, the incremental change in the co-pay will likely be less than \$4 per week." Commenters also pointed out that increasing co-payment amounts was beneficial to families to help them transition off child care assistance and thus avoid the cliff effect that comes with losing the subsidy.

Response: While we recognize the States' positions, for the following reasons, we are declining to change this for this final rule. Regarding the use of co-payments to manage budgets and wait lists, such ongoing incremental changes are to the overall detriment of participating families and ultimately undermine the effectiveness of the program. One of the commenters above mentioned that these co-payment increases are usually minor and would not impact the family's financial situation. Given this incremental financial benefit to the State, the administrative burden to both the family (notification with every change in income) and the State (having to track and adjust co-payments with minor changes for families throughout the year) outweighs the benefit gained. Additionally, a small increase (such as the \$4 increase mentioned above) may seem incremental from a policy perspective, but may represent a significant burden on low-income families managing the daily expenses of food, clothing, diapers, etc.

As for using co-payments to mitigate the impact of the cliff effect, this is an area where we agree. This is why § 98.21(e)(3) allows Lead Agencies to increase co-payments for families eligible due to the graduated phase-out provision. Since the graduated phase-out period (which will be discussed in the next section) was specifically designed to help families transition as their income rises, it is appropriate that co-payments be adjusted.

Graduated phase-out. New statutory language at Section 658E(c)(2)(N)(iv) of the Act requires Lead Agencies to have policies and procedures in place to allow for the provision of continued child care assistance at the time of re-determination for children of parents who are working or attending a job training or educational program and whose income has risen above the Lead Agency's initial income eligibility threshold to qualify for assistance but remains at or below 85 percent of State median income. Lead Agencies retain the authority to establish their initial income eligibility threshold at or below 85 percent of SMI. If a Lead Agency's initial eligibility threshold is set at 85 percent of SMI, it would be exempt from this requirement.

The proposed rule would have required Lead Agencies that set their initial income eligibility level below 85 percent of SMI (for a family of the same size) to provide for a graduated phase-out of assistance by establishing two-tiered eligibility (an initial, entry-level income threshold and a higher exit-level income threshold for families already

receiving assistance) with the exit threshold set at 85 percent of SMI. States would have had the option of either allowing the family to remain income eligible until the family exceeded 85% of SMI or for a limited period of not less than an additional 12 months.

The purpose of this graduated phase-out provision is to promote continuity of care and is consistent with the statutory requirement that families retain child care assistance during an eligibility period as their income increases. However, as discussed below, in response to comment, the final rule makes two significant changes to this requirement: (1) Offering additional flexibility on setting the second tier of eligibility, and (2) removing the possible time limit on eligibility.

Comment: We received mixed comment on the proposed graduated phase-out requirement. While commenters were supportive of improving continuity for families, a number of commenters indicated that they thought setting the two tiered system with the exit threshold at 85% of SMI was too restrictive. Commenters also raised similar concerns about the cost of this provision and the impact that it could potentially have on the demographics of CCDF families served. One commenter said that "the down side of this otherwise sensible policy idea is that, absent sufficient resources, lower income families may be denied access to subsidies while higher income families continue to benefit. It's a difficult tradeoff."

Response: Given the comments that we received in this area, and in recognition of the difficult trade-offs inherent in this policy, the final rule revises language proposed by the NPRM for the graduated phase-out provision. This final rule still requires Lead Agencies to establish two-tiered eligibility thresholds, but the graduated phase-out requirement at § 98.21(b) now says that the second tier of eligibility (used at the time of eligibility re-determination) will be set at 85 percent of SMI for a family of the same size, but that the Lead Agency has the option of establishing a second tier lower than 85% of SMI as long as that level is above the Lead Agency's initial eligibility threshold, takes into account the typical household budget of a low income family, and provides justification that the eligibility threshold is (1) sufficient to accommodate increases in family income that promote and support family economic stability; and (2) reasonably allows a family to continue accessing child care services without unnecessary disruption.

This revision from what was proposed in the NPRM will give Lead Agencies additional flexibility to establish their second tier of eligibility. However, it is important to note that once deemed eligible, the family shall be considered eligible for a full minimum 12-month eligibility period even if their income exceeds the second eligibility level during the eligibility period, as long as it does not exceed 85 percent of SMI.

While the revised regulatory language offers Lead Agencies some flexibility to set the second tier of eligibility, we still strongly encourage that Lead Agencies establish this second tier at 85 percent of SMI (as a number of States have already done). Not only does this maximize continuity of subsidy receipt for the family, linking the exit threshold to the Federal eligibility limit is the most straightforward approach for families to navigate and for Lead Agencies to implement. However, ACF also understands that there are significant trade-offs associated with establishing the second tier at 85% of SMI, including how many lower income families can be served in the program.

As a result, the final rule provides Lead Agencies flexibility to set their second tier below 85% of SMI, provided they show that their exit threshold takes into account typical family expenses, such as housing, food, health care, diapers, transportation, etc., and is set at an income level that promotes and supports family economic stability and reasonably allows a family to continue accessing child care services without unnecessary disruption. Lead Agencies setting their second tier below 85% of SMI must take into account a number of factors to determine whether the family's increase in income is a substantial enough change to justify a loss of assistance without causing a "cliff effect." For example, the Lead Agency would need to show that there is a difference between the first and second eligibility tiers and that this difference is sufficient to accommodate increases in income over time that are typical for low-income workers. ACF encourages Lead Agencies setting their second tier below 85% SMI to also consider how families that lose their subsidy will access ongoing child care and potential impacts on families' economic security.

Additionally, when determining a family's ability to afford child care, the Lead Agency should be mindful that this final rule uses seven percent of family income as a benchmark for affordable child care. While Lead Agencies have flexibility in establishing their sliding fee scales and determining what constitutes a cost barrier for

families, seven percent level is a recommended benchmark and any calculations about affordability should either incorporate this benchmark or provide justification for how families can afford to spend a higher percentage of their income on child care. Furthermore, to ensure Lead Agencies are fully taking into consideration the financial obligations of families, Lead agencies must also collect data on any amounts providers charge families more than the required family co-payment in instances where the provider's price exceeds the subsidy payment, if the State allows for such a practice, and to demonstrate a rationale for the allowance to charge families any additional amounts. This is mentioned in greater detail below in response to comments received specifically on the policies set forth in the proposed rule related to charging amounts above the co-payment. As for other concerns about the potential impact of the graduated phase-out provision, there are already several factors that will mitigate the possible negative impacts of this policy. First of all, the graduated phase-out provision provides some level of stability by protecting income growth, but there will still be natural attrition from the program due to other factors. Families have to go through redetermination every 12 months (or a longer period set by the Lead Agency) and be deemed otherwise eligible for the program. Families will also cycle out of the program through the Lead Agency option to terminate assistance due to job loss or cessation of education/training (after at least three months of continued assistance). According to analyses of CCDF administrative data, the current levels of attrition over time are steady and dramatic. Approximately 24 percent of families receive services for longer than a year, only about 10 percent receive it for 2 years, and the decline continues until approximately only 1 percent still receives the subsidy after 5 years. (Unpublished HHS tabulations based on CCDF administrative data reported by States on the ACF-801) We expect policies put into place to promote continuity will lengthen eligibility, but due to external factors, there will continue to be a turnover in the CCDF population.

In addition, the financial impact of this policy may be contained because: (1) The average cost of subsidy tends to naturally decline over time as the child's age increases, and (2) this final rule allows the Lead Agency to increase co-pays during the graduated phase-out period. CCDF administrative data shows that per child costs decline as the child

ages. This is due to the fact that school-age care is typically part-time for much of the year and less expensive than care provided for younger children. Therefore, the cost of the subsidy for families who remain on the program will naturally decline, which will free up resources for new enrollment.

As discussed further below, this final rule at section 98.21(b)(3) allows Lead Agencies to adjust co-payments during the graduated phase-out period. Over time, this would result in more cost sharing with families and free up State funds to allow other children to enter the subsidy system. As co-pays rise for parents with increasing incomes, families will naturally choose to leave the program.

Comment: There were objections to the second option of the proposed graduated phase-out proposal, which would have allowed Lead Agencies to offer a period of graduated phase-out for a limited period of not less than an additional 12 months. A number of commenters objected to "any provision that allows or encourages States to set arbitrary time limits on child care assistance," and said that "income, rather than time spent in the program, is a far better measure of families' need for continued assistance."

Response: We agree with this concern and have removed the provision from this final rule. The option was included in the proposed rule to provide some parameters around the graduated phase-out provision, but we recognize now that the introduction of a time limit to the program could have unintended consequences and runs counter to the goals of the program, including to support parents trying to achieve independence from public assistance. And as described above, there are factors already in play within the graduated phase-out provision that will naturally limit the fiscal impact of this over time. That, combined with the new flexibility on establishing the second eligibility threshold, makes the previous option of "a limited period of not less than an additional 12 months" unnecessary.

We have also added language at § 98.21(b)(2) to clarify that once determined eligible under the graduated phase-out provision, the family is considered eligible under the same conditions described in § 98.20 and § 98.21, with the exception of the co-payment restrictions at § 98.21(a)(3). Pursuant to § 98.21(a)(3), Lead Agencies are prohibited from increasing family co-payments within the minimum 12-month eligibility period. However, in subparagraph (b)(2) of this section, Lead Agencies will be permitted to adjust

family co-payment amounts during the graduated phase-out period to help families transition off of child care assistance as they become better able to afford the cost of care.

Lead Agencies have the option to gradually increase co-payments for families with children eligible under the graduated phase-out provision and may require additional reporting on changes to do so. However, this final rule further clarifies that such additional reporting requirements must not constitute an undue burden, pursuant to the conditions in (e)(2)(ii) and (e)(2)(iii). Such requirements must not require an office visit in order to fulfill notification requirements, and must offer a range of notification options (e.g., phone, email, online forms, extended submission hours) to accommodate the needs of parents.

While such co-payment policies should help families gradually transition off of assistance, ACF encourages Lead Agencies to ensure that co-payment increases are gradual in proportion to a family's income growth and do not constitute too high a cost burden for families so as to ensure stability as family income increases. Lead Agencies must remain in compliance with the statutory requirement at Section 658E(c)(5) that the State's sliding fee scale is not a barrier to families receiving CCDF assistance.

Income eligibility policies play an important role in promoting pathways to financial stability for families. Currently, 16 Lead Agencies use two-tiered income eligibility. However, even with higher exit-level eligibility thresholds in these States/Territories, a small increase in earnings may result in families becoming ineligible for assistance before they are able to afford the full cost of care. While there are many factors that determine how a State sets their eligibility thresholds, an unintended consequence of low eligibility thresholds is that low income parents may pass up raises or job advancement in order to retain their subsidy, which undermines a key goal of CCDF to help parents achieve independence from public assistance. This rule allows low-income families to continue child care assistance as their income grows in order to support financial stability.

Irregular fluctuations in earnings. In § 98.21(c), we reiterate statutory language at Section 658E(c)(2)(N)(i)(II) of the Act which requires Lead Agencies to establish processes for initial determination and re-determination of eligibility that take into account parents' irregular fluctuations in earnings. We

clarify that temporary increases in income should not affect eligibility or family co-payments, including monthly income fluctuations that show *temporary* increases, which if considered in isolation, may incorrectly indicate that a family is above the federal threshold of 85 percent of SMI, when in actuality their annual income remains at or below 85 percent of SMI.

Lead Agencies retain broad flexibility to set their policies and procedures for income calculation and verification. There are several approaches Lead Agencies may take to account for irregular fluctuations in earnings. Lead Agencies may average family earnings over a period of time (e.g., 12 months) to better reflect a family's financial situation; Lead Agencies may adjust documentation requirements to better account for average earnings, for example, by requesting the earnings statement that is most representative of the family's income, rather than the most recent statement; or Lead Agencies may choose to discount temporary increases in income provided that a family demonstrates that an isolated increase in pay (e.g., short-term overtime pay, lump sum payments such as tax credits, etc.) is not indicative of a permanent increase in income.

We did not receive substantive comment in this section and are therefore retaining the proposed language in this final rule.

Undue disruption. In accordance with Section 658E(c)(2)(N)(i)(II) of the Act, the final rule adds § 98.21(d), which requires the Lead Agency to establish procedures and policies to ensure that parents, especially parents receiving TANF assistance, are not required to unduly disrupt their education, training, or employment in order to complete the eligibility re-determination process. This provision of the Act seeks to protect parents from losing assistance for failure to meet renewal requirements that place unnecessary barriers or burdens on families, such as requiring parents to take leave from work in order to submit documentation in person or requiring parents to resubmit documents that have not changed (e.g., children's birth certificates).

To meet this provision, Lead Agencies could offer a variety of family-friendly mechanisms through which parents could submit required documentation (e.g., phone, email, online forms, extended submission hours, etc.). Lead Agencies could also consider strategies that inform families, and their providers, of an upcoming re-determination and what is required of the family. Lead Agencies could consider only asking for information

necessary to make an eligibility determination or only asking for information that has changed and not asking for documentation to be re-submitted if it has been collected in the past (e.g., children's birth certificates; parents' identification, etc.) or is available from other electronic data sources (e.g., verified data from other benefit programs). Lead Agencies can pre-populate renewal forms and have parents confirm that information is accurate.

In general, ACF strongly encourages Lead Agencies to adopt reasonable policies for establishing a family's eligibility that minimize burdens on families. Given the new eligibility provisions established by reauthorization, Lead Agencies are encouraged to re-evaluate processes for verifying and tracking eligibility to simplify eligibility procedures and reduce duplicative requirements across programs. Simplifying and streamlining eligibility processes along with other changes in the subpart may require significant change within the CCDF program. Lead Agencies should provide appropriate training and guidance to ensure that caseworkers and other relevant child care staff (including those working for designated entities) clearly understand new policies and are implementing them correctly. Comments received in this section were supportive of the proposed policies and we are therefore keeping these provisions in this final rule.

Reporting changes in circumstance. Currently, many Lead Agencies have policies in place to monitor eligibility on an ongoing basis to ensure that at any given point in time a family is eligible for services, often called change-reporting or interim-reporting. As the revised statute provides that children may retain eligibility through most changes in circumstance, it is our belief that comprehensive reporting of changes in circumstance is not only unnecessary but runs counter to CCDF's goals of promoting continuity of care and supporting families' financial stability.

Additionally, there are challenges associated with interim monitoring and reporting, including costs to families trying to balance work or education and family obligations and costs to Lead Agencies administering the program. Overly burdensome reporting requirements can also result in increased procedural errors, as even parents who remain eligible may face difficulties complying with onerous reporting rules.

Lead Agencies should significantly reduce change reporting requirements for families within the eligibility period,

and limit the reporting requirements to changes that impact federal CCDF eligibility. Section 98.21(e) of final rule requires Lead Agencies to specify in their Plans any requirements for families to notify the Lead Agency (or its designee) of changes in circumstances between eligibility periods, and describe efforts to ensure such requirements do not place an undue burden on eligible families that could impact continued eligibility between re-determinations.

Under § 98.21(e)(1), the Lead Agency must require families to report a change at any point during the minimum 12-month period only when the family's income exceeds 85% of SMI, taking into account irregular income fluctuations. At the option of the Lead Agency, the Lead Agency may require families to report changes where the family has experienced a non-temporary cessation of work, training, or education.

Section 98.21(e)(2) specifies that any notification requirements may not constitute an undue burden on families and that compliance with requirements must include a range of notification options (e.g., phone, email, online forms, extended submission hours) and not require an in-person office visit. This includes parents who are working, as well as those participating in job training or educational programs.

The final rule also limits notification requirements only to items that impact a family's eligibility (e.g., income changes over 85 percent of SMI, and at Lead Agency option, the status of the child's parent as working or attending a job training or educational program) or those that are necessary for the Lead Agency to contact the family or pay providers (e.g., a family's change of address or a change in the parent's choice of provider). Lead Agencies may examine additional eligibility criteria at the time of the next re-determination.

Section 98.21(e)(4) requires Lead Agencies to allow families the option of reporting information on an ongoing basis, particularly to allow families to report information that would be beneficial to their assistance (such as an increase in work hours that necessitates additional child care hours or a loss of earnings that could result in a reduction of the family co-payment). While we encourage limiting reporting requirements for families, it was not our intent to limit the family's ability to report changes in circumstances, particularly in cases where they may have entered into more stressful or vulnerable situations or would be eligible for additional child care assistance. Moreover, if a family voluntarily reports changes on an

45 CFR 98.21 - Eligibility determination processes.

§ 98.21 Eligibility determination processes.

(a) A Lead Agency shall re-determine a child's eligibility for child care services no sooner than 12 months following the initial determination or most recent redetermination, subject to the following:

(1) During the period of time between determinations or redeterminations, if the child met all of the requirements in § 98.20(a) on the date of the most recent eligibility determination or redetermination, the child shall be considered eligible and will receive services at least at the same level, regardless of:

(i) A change in family income, if that family income does not exceed 85 percent of SMI for a family of the same size; or

(ii) A temporary change in the ongoing status of the child's parent as working or attending a job training or educational program. A temporary change shall include, at a minimum:

(A) Any time-limited absence from work for an employed parent due to reasons such as need to care for a family member or an illness;;

(B) Any interruption in work for a seasonal worker who is not working between regular industry work seasons;

(C) Any student holiday or break for a parent participating in training or education;

(D) Any reduction in work, training or education hours, as long as the parent is still working or attending training or education;

(E) Any other cessation of work or attendance at a training or education program that does not exceed three months or a longer period of time established by the Lead Agency;

(F) Any change in age, including turning 13 years old during the eligibility period; and

(G) Any change in residency within the State, Territory, or Tribal service area.

(2)

(i) Lead Agencies have the option, but are not required, to discontinue assistance due to a parent's loss of work or cessation of attendance at a job training or educational program that does not constitute a temporary change in accordance with paragraph (a) (1)(ii) of this section. However, if the Lead Agency exercises this option, it must continue

assistance at least at the same level for a period of not less than three months after each such loss or cessation in order for the parent to engage in job search and resume work, or resume attendance at a job training or educational activity.

(ii) At the end of the minimum three-month period of continued assistance, if the parent is engaged in a qualifying work, education, or training activity with income below 85% of SMI, assistance cannot be terminated and the child must continue receiving assistance until the next scheduled re-determination, or at Lead Agency option, for an additional minimum 12 - month eligibility period.

(iii) If a Lead Agency chooses to initially qualify a family for CCDF assistance based a parent's status of seeking employment or engaging in job search, the Lead Agency has the option to end assistance after a minimum of three months if the parent has still not found employment, although assistance must continue if the parent becomes employed during the job search period.

(3) Lead Agencies cannot increase family co-payment amounts, established in accordance with § 98.45(k), within the minimum 12-month eligibility period except as described in paragraph (b)(3) of this section.

(4) Because a child meeting eligibility requirements at the most recent eligibility determination or redetermination is considered eligible between redeterminations as described in paragraph (a)(1) of this section, any payment for such a child shall not be considered an error or improper payment under subpart K of this part due to a change in the family's circumstances.

(5) Notwithstanding paragraph (a)(1), the Lead Agency may discontinue assistance prior to the next re-determination in limited circumstances where there have been:

(i) Excessive unexplained absences despite multiple attempts by the Lead Agency or designated entity to contact the family and provider, including prior notification of possible discontinuation of assistance;

(A) If the Lead Agency chooses this option, it shall define the number of unexplained absences that shall be considered excessive;

(B) [Reserved]

(ii) A change in residency outside of the State, Territory, or Tribal service area; or

(iii) Substantiated fraud or intentional program violations that invalidate prior determinations of eligibility.

(b)

(1) Lead Agencies that establish family income eligibility at a level less than 85 percent of SMI for a family of the same size (in order for a child to initially qualify for assistance) must provide a graduated phase-out by implementing two-tiered eligibility thresholds, with the second tier of eligibility (used at the time of eligibility re-determination) set at:

(i) 85 percent of SMI for a family of the same size; or

(ii) An amount lower than 85 percent of SMI for a family of the same size, but above the

Lead Agency's initial eligibility threshold, that:

(A) Takes into account the typical household budget of a low income family; and

(B) Provides justification that the second eligibility threshold is:

(1) Sufficient to accommodate increases in family income over time that are typical for low-income workers and that promote and support family economic stability; and

(2) Reasonably allows a family to continue accessing child care services without unnecessary disruption.

(2) At re-determination, a child shall be considered eligible (pursuant to paragraph (a) of this section) if their parents, at the time of redetermination, are working or attending a job training or educational program even if their income exceeds the Lead Agency's income limit to initially qualify for assistance, as long as their income does not exceed the second tier of the eligibility described in (b)(1);

(3) A family meeting the conditions described in (b)(2) shall be eligible for services pursuant to the conditions described in § 98.20 and all other paragraphs of § 98.21, with the exception of the co-payment restrictions at § 98.21(a)(3). To help families transition off of child care assistance, Lead Agencies may gradually adjust co-pay amounts for families whose children are determined eligible under the graduate phase-out conditions described in paragraph (b)(2) and may require additional reporting on changes in family income as described in paragraph (e)(3) of this section, provided such requirements do not constitute an undue burden, pursuant to conditions described in (e)(2)(ii) and (iii) of this section.

(c) The Lead Agency shall establish processes for initial determination and redetermination of eligibility that take into account irregular fluctuation in earnings, including policies that ensure temporary increases in income, including temporary increases that result in monthly income exceeding 85 percent of SMI (calculated on a monthly basis), do not affect eligibility or family co-payments.

(d) The Lead Agency shall establish procedures and policies to ensure parents, especially parents receiving assistance through the Temporary Assistance for Needy Families (TANF) program, are not required to unduly disrupt their education, training, or employment in order to complete the eligibility redetermination process.

(e) The Lead Agency shall specify in the Plan any requirements for parents to notify the Lead Agency of changes in circumstances during the minimum 12-month eligibility period, and describe efforts to ensure such requirements do not place an undue burden on eligible families that could impact continued eligibility between redeterminations.

(1) The Lead Agency must require families to report a change at any point during the minimum 12-month period, limited to:

(i) If the family's income exceeds 85% of SMI, taking into account irregular income fluctuations; or

(ii) At the option of the Lead Agency, the family has experienced a non-temporary cessation of work, training, or education.

(2) Any additional requirements the Lead Agency chooses, at its option, to impose on parents to provide notification of changes in circumstances to the Lead Agency or entities designated to perform eligibility functions shall not constitute an undue burden on families. Any such requirements shall:

(i) Limit notification requirements to items that impact a family's eligibility (*e.g.*, only if income exceeds 85 percent of SMI, or there is a non-temporary change in the status of the child's parent as working or attending a job training or educational program) or those that enable the Lead Agency to contact the family or pay providers;

(ii) Not require an office visit in order to fulfill notification requirements; and

(iii) Offer a range of notification options (*e.g.*, phone, email, online forms, extended submission hours) to accommodate the needs of parents;

(3) During a period of graduated phase-out, the Lead Agency may require additional reporting on changes in family income in order to gradually adjust family co-payments, if desired, as described in paragraph (b)(3) of this section.

(4) Lead Agencies must allow families the option to voluntarily report changes on an ongoing basis.

(i) Lead Agencies are required to act on this information provided by the family if it would reduce the family's co-payment or increase the family's subsidy.

(ii) Lead Agencies are prohibited from acting on information that would reduce the family's subsidy unless the information provided indicates the family's income exceeds 85 percent of SMI for a family of the same size, taking into account irregular income fluctuations, or, at the option of the Lead Agency, the family has experienced a non-temporary change in the work, training, or educational status.

(f) Lead Agencies must take into consideration children's development and learning and promote continuity of care when authorizing child care services.

(g) Lead Agencies are not required to limit authorized child care services strictly based on the work, training, or educational schedule of the parent(s) or the number of hours the parent(s) spend in work, training, or educational activities.

[81 FR 67579, Sept. 30, 2016]

45 CFR 98.41 - Health and safety requirements.

§ 98.41 Health and safety requirements.

(a) Each Lead Agency shall certify that there are in effect, within the State (or other area served by the Lead Agency), under State, local or tribal law, requirements (appropriate to provider setting and age of children served) that are designed, implemented, and enforced to protect the health and safety of children. Such requirements must be applicable to child care providers of services for which assistance is provided under this part. Such requirements, which are subject to monitoring pursuant to § 98.42, shall:

(1) Include health and safety topics consisting of, at a minimum:

(i) The prevention and control of infectious diseases (including immunizations); with respect to immunizations, the following provisions apply:

(A) As part of their health and safety provisions in this area, Lead Agencies shall assure that children receiving services under the CCDF are age-appropriately immunized. Those health and safety provisions shall incorporate (by reference or otherwise) the latest recommendation for childhood immunizations of the respective State, territorial, or tribal public health agency.

(B) Notwithstanding this paragraph (a)(1)(i), Lead Agencies may exempt:

(1) Children who are cared for by relatives (defined as grandparents, great grandparents, siblings (if living in a separate residence), aunts, and uncles), provided there are no other unrelated children who are cared for in the same setting.

(2) Children who receive care in their own homes, provided there are no other unrelated children who are cared for in the home.

(3) Children whose parents object to immunization on religious grounds.

(4) Children whose medical condition contraindicates immunization.

(C) Lead Agencies shall establish a grace period that allows children experiencing homelessness and children in foster care to receive services under this part while providing their families (including foster families) a reasonable time to take any necessary action to comply with immunization and other health and safety requirements.

(1) The length of such grace period shall be established in consultation with the State, Territorial or Tribal health agency.

(2) Any payment for such child during the grace period shall not be considered an

error or improper payment under subpart K of this part.

(3) The Lead Agency may also, at its option, establish grace periods for other children who are not experiencing homelessness or in foster care.

(4) Lead Agencies must coordinate with licensing agencies and other relevant State, Territorial, Tribal, and local agencies to provide referrals and support to help families of children receiving services during a grace period comply with immunization and other health and safety requirements;

- (ii)** Prevention of sudden infant death syndrome and use of safe sleeping practices;
- (iii)** Administration of medication, consistent with standards for parental consent;
- (iv)** Prevention and response to emergencies due to food and allergic reactions;
- (v)** Building and physical premises safety, including identification of and protection from hazards, bodies of water, and vehicular traffic;
- (vi)** Prevention of shaken baby syndrome, abusive head trauma, and child maltreatment;
- (vii)** Emergency preparedness and response planning for emergencies resulting from a natural disaster, or a man-caused event (such as violence at a child care facility), within the meaning of those terms under section 602(a)(1) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5195a(a)(1)) that shall include procedures for evacuation, relocation, shelter-in-place and lock down, staff and volunteer emergency preparedness training and practice drills, communication and reunification with families, continuity of operations, and accommodation of infants and toddlers, children with disabilities, and children with chronic medical conditions;
- (viii)** Handling and storage of hazardous materials and the appropriate disposal of biocontaminants;
- (ix)** Appropriate precautions in transporting children, if applicable;
- (x)** Pediatric first aid and cardiopulmonary resuscitation;
- (xi)** Recognition and reporting of child abuse and neglect, in accordance with the requirement in paragraph (e) of this section; and
- (xii)** May include requirements relating to:
 - (A)** Nutrition (including age-appropriate feeding);
 - (B)** Access to physical activity;
 - (C)** Caring for children with special needs; or
 - (D)** Any other subject area determined by the Lead Agency to be necessary to promote child development or to protect children's health and safety.

(2) Include minimum health and safety training on the topics above, as described in § 98.44.

(b) Lead Agencies may not set health and safety standards and requirements other than those required in paragraph (a) of this section that are inconsistent with the parental choice safeguards in § 98.30(f).

(c) The requirements in paragraph (a) of this section shall apply to all providers of child care services for which assistance is provided under this part, within the area served by the Lead Agency, except the relatives specified at § 98.42(c).

(d) Lead Agencies shall describe in the Plan standards for child care services for which assistance is provided under this part, appropriate to strengthening the adult and child relationship in the type of child care setting involved, to provide for the safety and developmental needs of the children served, that address:

(1) Group size limits for specific age populations;

(2) The appropriate ratio between the number of children and the number of caregivers, in terms of age of children in child care; and

(3) Required qualifications for caregivers in child care settings as described at § 98.44(a)
(4).

(e) Lead Agencies shall certify that caregivers, teachers, and directors of child care providers within the State or service area will comply with the State's, Territory's, or Tribe's child abuse reporting requirements as required by section 106(b)(2)(B)(i) of the Child Abuse and Prevention and Treatment Act (42 U.S.C. 5106a(b)(2)(B)(i)) or other child abuse reporting procedures and laws in the service area.

[81 FR 67582, Sept. 30, 2016]



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Center for Medicaid and CHIP Services

SMD # 17-001

**RE: Implications of the Cures Act
for Special Needs Trusts**

August 2, 2017

Dear State Medicaid Director:

Section 5007 of the 21st Century Cures Act (the “Cures Act”), Pub. L. No. 114-255, supports the independence of individuals with disabilities by permitting them to set up a special needs trust on their own behalf, rather than having to rely on a third party to do so. Special needs trusts generally permit individuals living with disabilities who are under age 65 to set aside assets to meet their needs without impacting their eligibility for Medicaid. This letter provides guidance to states on the implications of section 5007 of the Cures Act, entitled “Fairness in Medicaid Supplemental Needs Trusts,” for individuals who have disabilities.

Background

Section 1917(d)(3) of the Social Security Act (the Act) prescribes the rules state Medicaid agencies must apply in evaluating funds in, contributions to, and distributions from, trusts that are funded with a Medicaid applicant’s or beneficiary’s own assets. In the case of a revocable trust, the general rule is that the corpus is considered an available resource to the individual; any distributions from the corpus to or for the benefit of the individual are considered income to the individual; and any distributions or payments from the corpus used for other purposes are treated as an asset transfer subject to the provisions of section 1917(c) of the Act. Under section 1917(c) of the Act, an asset transfer may result in a coverage penalty if the individual seeks coverage of nursing facility or other long-term services and supports but did not receive fair market value in return for the transfer.

In the case of an irrevocable trust, if payments may be made to or for the individual’s benefit from any portion of the corpus, that portion is considered an available resource to the individual, and payments from that portion made to or for the individual’s benefit are considered income to the individual; otherwise, any payment made from the portion of an irrevocable trust that may be used for the individual’s benefit is treated as an asset transfer subject to section 1917(c) of the Act. Further, if the individual’s income or assets are used to fund an irrevocable trust, any portion of the corpus funded by such income or assets from which no payment may be made to or for the benefit of the individual under any circumstances shall be treated, under section 1917(d)(3)(B) of the Act, as an asset transfer subject to section 1917(c) of the Act.¹

¹ If only a portion of the individual’s assets placed in the trust is unavailable to or for the benefit of the individual, that portion is considered an asset transfer subject to the rules of section 1917(c) of the Act.

Under section 1917(d)(4) of the Act, certain types of trusts (“section 1917(d)(4) trusts”) are not subject to the rules set forth in section 1917(d)(3) of the Act described above, but instead, are most commonly evaluated under the general trust rules of the supplemental security income program (SSI) program.² Under these rules, the corpus of a revocable trust which is funded with an individual’s assets and which can be used for the individual’s benefit is generally a countable resource to the individual, but distributions from the trust for the individual’s benefit are considered a conversion of a resource (instead of as countable income, as is generally the case under section 1917(d)(3) of the Act). Under general SSI trust rules, the corpus of an irrevocable trust funded with an individual’s assets is not generally a countable resource to the individual, even if the corpus may be used for the individual’s benefit, although payments from the irrevocable trust to the individual or on his or her behalf will generally be countable income to the individual.

Section 1917(c)(2)(B)(iv) of the Act also exempts from asset transfer penalties transfers of income or assets to a trust which is established solely for the benefit of a person with a disability under age 65. Thus, the application of SSI rules regarding irrevocable trusts, in conjunction with section 1917(c)(2)(B)(iv) of the Act, means that an irrevocable special needs trust described in section 1917(d)(4)(A) of the Act, established for a person with a disability who is under age 65 using the individual’s own assets, is neither counted as a resource nor subject to the transfer-of-asset penalties.

Special Needs Trusts Under the Cures Act

For a trust to meet the definition of a “special needs trust” described in section 1917(d)(4)(A) of the Act, the trust must: contain the assets of an individual under age 65 who has a disability; be established for the benefit of such individual; and direct that the state will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid by the state on the individual’s behalf. Prior to the Cures Act, a special needs trust also had to be established by a parent, grandparent, legal guardian of the individual, or a court.³

The requirement that a third party establish a special needs trust, which is not imposed on the other section 1917(d)(4) trusts, was identified by many stakeholders as a barrier to maximizing the independence of people with disabilities. Section 5007(a) of the Cures Act addressed this criticism for special needs trusts established on or after the date of the law’s enactment, December 13, 2016.

Specifically, section 5007(a) of the Cures Act amended section 1917(d)(4)(A) of the Act to add “the individual” (i.e., the trust beneficiary) to the list of people who may establish a special needs

² See SI 01120.200 of the Social Security Administration’s Program Operations Manual System (POMS), “Trusts, General – Including Trusts Established Prior to 1/1/00, Trusts Established with the Asset of Third Parties and Trusts Not Subject to Section 1613(e) of the Social Security Act,” available at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120200>.

³ While a special needs trust must be established using income or assets of the trust beneficiary, third party contributions to a special needs trust are permitted, provided that the individual is the sole beneficiary of the trust. (See Section 3259.7(A) of the State Medicaid Manual.)

trust on the individual's behalf. This means that a trust established on or after December 13, 2016, by an individual with a disability under age 65 for his or her own benefit can qualify as a special needs trust, conferring the same benefits as a special needs trust set up by a parent, grandparent, legal guardian or court.

The other defining features of a special needs trust remain unchanged under the amendments made by the Cures Act – i.e., the individual must be under age 65 and have a disability; the trust must be funded, at least in part, with the individual's own income or assets; and the terms of the trust must direct that amounts remaining in the trust upon the death of the individual will be paid to the state up to an amount equal to total medical assistance paid. Trusts established prior to December 13, 2016, by an individual with a disability for his or her own benefit do not qualify as a special needs trust. However, trusts established by an eligible third party before and after this date still qualify as a special needs trust.

Please update your state's Medicaid trusts rules accordingly. If you have any questions, please contact Gene Coffey at (410) 786-2234, or gene.coffey@cms.hhs.gov, or your SOTA team lead.

Sincerely,

/s/

Brian Neale
Director

65 IDELR 21

115 LRP 5832

**Letter to Kotler
Office of Special Education Programs**

N/A

November 12, 2014

Related Index Numbers

525.003 In General

175.070 Visual Impairment

470.010 Authority to Set Standards

Judge / Administrative Officer

Melody Musgrove, Director

Ruling

States' definitions of "visual impairment" need not precisely track the IDEA's language; however, they must not exclude children who would otherwise be IDEA-eligible under that classification, OSEP informed a parent's attorney.

Meaning

Visual impairments under the IDEA include both blindness and partial vision. The key isn't the type of eye condition the child has, or whether the condition limits the ability to see distances or to see near, but whether it adversely affects the child's educational performance. Thus, districts determining whether a child is or may be eligible under the IDEA based on a visual impairment need to consider factors such as whether the condition impacts the child's ability to use assistive technology, complete school work, including reading and math, and otherwise be involved in and progress in the general education curriculum.

Case Summary

In conducting child find and eligibility determinations, districts must be careful not to overlook children with near vision problems, even when they might otherwise pass an eye exam. OSEP told a parent's attorney that any condition that results in either blindness or partial sight and that could affect a child's educational performance may qualify

the student to receive special education and related services. The attorney indicated that the District of Columbia (and some states) use eligibility criteria for visual impairments that exclude children whose conditions, such as convergence insufficiency (where the eyes do not properly turn inward to focus), affect their ability to read and write. OSEP pointed out that a visual impairment under the IDEA implementing regulation at 34 CFR 300.8(c)(13) means any vision impairment, including blindness, that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness. "States may not use criteria or other definitions for 'visual impairment including blindness' that result in the exclusion of children who otherwise meet the definition in 34 CFR § 300.8(c)(13)," OSEP Director Melody Musgrove wrote. OSEP further noted that a proper vision evaluation should consider how the impairment affects the child's ability to learn to read, write, do math, use computers, and participate and make progress in the general curriculum. OSEP informed the attorney that it would work with the District of Columbia Office of State Superintendent of Education to ensure that the District of Columbia Public Schools' eligibility guidelines are consistent with state standards and the IDEA.

Full Text

Dear Ms. Kotler:

This is in response to your letter to the Office of Special Education Programs (OSEP) regarding the criteria used by some States to identify children with "visual impairments or blindness," as that term is defined under Part B of the Individuals with Disabilities Education Act (IDEA). In your letter, you provide, as an example, the criteria used by the District of Columbia Public Schools (DCPS) to determine eligibility for special education and related services under Part B of the IDEA based on visual impairment or blindness.¹ You indicate that the criteria are inconsistent with Federal regulations because they exclude children whose vision problems affect their ability to read and write. Furthermore, you

indicate that an example of a vision condition that severely impairs learning is "convergence insufficiency" and that some States' definitions of "visual impairment" exclude children with such a condition.

Under Part B of the IDEA a child with a disability means a child evaluated in accordance with 34 CFR §§ 300.304-300.311 as having a disability, and who, by reason thereof, needs special education and related services. 34 CFR § 300.8(a)(1). Further, under 34 CFR § 300.8(c)(13), "visual impairment including blindness" means an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness. OSEP understands that convergence insufficiency results when a person's eyes do not properly turn inward to focus and provide binocular vision and a single image, which could affect a child's ability to read, and therefore, the child's educational performance.

While States may establish standards for eligibility for special education and related services, and are not required to use the precise definition of disability terms in the IDEA, these State-established standards must not narrow the definition in the IDEA. It is important to note that States define or adopt common definitions of certain ambiguous modifiers to guide evaluators in making individualized determinations of eligibility. For example, where the definition of "intellectual disability"² refers to "significantly subaverage general intellectual functioning," 34 CFR § 300.8(c)(6), and, similarly, where the definition of "orthopedic impairment" refers to "severe orthopedic impairment that adversely affects a child's educational performance," States are given discretion to determine the precise level of impairment that qualifies as significant, and severe, respectively, in order for evaluators to implement those definitions. In contrast, the definition of "visual impairment including blindness," does not contain a vague modifier; rather, any impairment in vision, regardless of severity, is covered, provided that such

child's educational performance.

Accordingly, States may not use criteria or other definitions for "visual impairment including blindness" that result in the exclusion of children who otherwise meet the definition in 34 CFR § 300.8(c)(13). State eligibility guidelines and definitions for visual impairment and blindness may not exclude a child with convergence insufficiency or other visual impairment from meeting the definition in the IDEA for visual impairment and blindness if that condition adversely affects that child's educational performance.

The evaluation of vision status and the need for special education and related services should be thorough and rigorous, include a data-based media assessment, be based on a range of learning modalities, including auditory, tactile, and visual, and include a functional visual assessment. An assessment of a child's vision status generally would include the nature and extent of the child's visual impairment, and its affect, for example, on the child's ability to learn to read, write, do mathematical calculations, and use computers and other assistive technology, as well as the child's ability to be involved in and make progress in the general curriculum offered to nondisabled students. Such an evaluation generally would be closely linked to the assessment of the child's present and future reading and writing objectives, needs, and appropriate reading and writing media. The information obtained through the evaluation generally should be used by the IEP Team in determining whether it would be appropriate to provide a blind or visually impaired child with special education instruction or related services as required by the IDEA. In addition, because the evaluation must assess a child's future needs, a child's current vision status should not necessarily determine whether it would be inappropriate for that child to receive special education and related services while in school. Please see OSEP's Dear Colleague Letter on Braille, June 19, 2013,

cyberFEDS® Case Report

With respect to the definition used by DCPS, as the State educational agency for the District of Columbia, OSSE is responsible for establishing and implementing procedures for ensuring that all eligible children with disabilities are identified, located and evaluated, and that a free appropriate public education is made available to all such children. OSSE is also responsible for ensuring that Part B funds are not used to serve children who do not meet the Part B definition of "child with a disability." It is the role of OSSE, rather than this office, to establish State standards for determining eligibility (so long as they are consistent with Part B requirements), and to determine whether DCPS' eligibility guidelines are consistent with State standards, and the requirements of Part B of the IDEA. OSEP will work with OSSE to address this issue.

Based on section 607(e) of the IDEA, we are informing you that our response is provided as informal guidance and is not legally binding, but represents an interpretation by the U.S. Department of Education of the IDEA in the context of the specific facts presented.

Thank you for bringing this matter to our attention. If you have questions, please do not hesitate to contact Jennifer Denny at 202-245-6331 or by email at Jennifer.Denny@ed.gov.

¹Your letter included a copy of the Office of the State Superintendent of Education's (OSSE) Letter of Decision for State Complaint No. 013-004 dated October 16, 2013, in which OSSE identified the five eligibility criteria used by DCPS under the category of visual impairment including blindness:

1. Central acuity with corrective lenses 20/70 in the better eye with correction, or
2. Reduced visual field to 50 degrees or less in the better eye, or
3. A diagnosis of cortical visual impairment, or
4. A diagnosis of a degenerative condition that is likely to result in a significant loss of vision in the future. or

irremediable through medical or therapeutic intervention that has adverse effect on educational performance.

²Rosa's Law (P.L. 111-256) replaced references to "mental retardation" or "mentally retarded" with "intellectual disability" in all Federal health, education, and labor policy.

Cases Cited

61 IDELR 172



UNITED STATES DEPARTMENT OF EDUCATION
OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

May 22, 2017

Contact Person
Name: Lisa Pagano
Telephone: (202) 245-7413

OSEP 17-05

MEMORANDUM

TO: State Directors of Special Education, Preschool/619 State Coordinators

FROM: Ruth E. Ryder
Acting Director
Office of Special Education Programs

SUBJECT: Eligibility Determinations for Children Suspected of Having a Visual Impairment Including Blindness under the Individuals with Disabilities Education Act

On November 12, 2014, the Office of Special Education Programs (OSEP) issued a response to an inquiry for policy clarification addressing whether a State educational agency (SEA) and/or local educational agency (LEA) is permitted to establish procedures that further define the disability category, “visual impairment including blindness,” under the Individuals with Disabilities Education Act (IDEA).¹ Since that time, OSEP has received a request for written guidance to assist SEAs in supporting their LEAs in reaching appropriate eligibility determinations for children with this disability. The purpose of this memorandum is to ensure broad dissemination of the key points made in our November 12, 2014 letter, provide the additional guidance requested on this important issue, and share information about outside resources that may be helpful as you examine your State’s procedures related to the identification and evaluation of children suspected of having a visual impairment including blindness.

Applicable IDEA Definitions

Under Part B of the IDEA, a child with a disability means a child evaluated in accordance with 34 CFR §§300.304-300.311 as having a disability, and who, by reason thereof, needs special education and related services. 34 CFR §300.8(a)(1). Further, under 34 CFR §300.8(c)(13),

¹ See OSEP *Letter to Kotler* available at: <https://www2.ed.gov/policy/speced/guid/idea/memosdcltrs/acc-13-020197r-md-kotlereeligibilitycriteria.pdf>.

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“visual impairment including blindness” means an impairment in vision that, *even with correction*, adversely affects a child’s educational performance. (Emphasis added) The term includes both partial sight and blindness.

State and Local Eligibility Criteria

While States are permitted to establish standards for eligibility for special education and related services, and are not required to use the precise definition of a disability term in the IDEA, these State-established standards must not narrow the definitions in the IDEA. We recognize that States often adopt common definitions of certain modifiers to guide evaluators in making individualized eligibility determinations. For example, as OSEP noted in our November 12, 2014 letter, “intellectual disability” refers to “*significantly* subaverage general intellectual functioning,” (34 CFR §300.8(c)(6)), and similarly, the definition of “orthopedic impairment” refers to “a *severe* orthopedic impairment that adversely affects a child’s educational performance” (34 CFR §300.8(c)(8)). In these cases, because the IDEA does not specifically address the meaning of these modifiers, the IDEA gives States discretion to determine the precise level of impairment that qualifies as “*significantly*,” and “*severe*,” respectively, in order for evaluators and eligibility teams to implement these definitions.

In contrast, in the definition of “visual impairment including blindness,” the regulations do not contain a modifier; therefore, *any* impairment in vision, regardless of significance or severity, must be included in a State’s definition, provided that such impairment, even with correction, adversely affects a child’s educational performance. States may not use criteria or other definitions for “visual impairment including blindness” that result in the exclusion of children who otherwise meet the definition in 34 CFR §300.8(c)(13). For example, State eligibility guidelines and definitions for “visual impairment including blindness” may not exclude a child with convergence insufficiency or other visual impairment from meeting the IDEA’s definition of “visual impairment including blindness” if that condition, even with correction, adversely affects that child’s educational performance (e.g., the child’s ability to read and write).

It has come to our attention that some States direct their LEAs to implement a two-step process when addressing whether a child suspected of having a visual impairment may be eligible for special education and related services under the IDEA. During the first step, the eligibility team is required to reach a decision as to whether the child has one or more of the conditions that the State has identified and believes could affect a child’s vision functioning. Examples of such conditions might include: the child has a reduced visual field to 50 degrees or less in the better eye; the child has been diagnosed with cortical visual impairment; or the child has a diagnosis of a degenerative condition that is likely to result in a significant loss of vision in the future. During the second step, the eligibility team determines the extent that it should proceed further and examine whether the condition adversely affects the child’s educational performance. However, if the eligibility team were to conclude the child’s vision difficulties do not fall within one of the

State's listed criteria or conditions, the eligibility team would not consider whether the child's visual functioning adversely affects his or her educational performance. Such a practice is inconsistent with the IDEA. While it is permissible for a State to provide *examples* of the types of conditions that would meet the State's criteria for "visual impairment including blindness," the SEA or LEA may not preclude eligibility teams from considering whether *other* vision conditions, even with correction, adversely affect the child's educational performance such that the child requires special education and related services under the IDEA.

For more information about various types of visual impairments and the ways in which those impairments can affect a child's ability to learn, visit <http://www.parentcenterhub.org/repository/visualimpairment/>.

Evaluation to Determine Whether the Child's Visual Impairment Adversely Affects Educational Performance

Prior to the eligibility determination, each public agency must conduct a full and individual evaluation, in accordance with 34 CFR §§300.304-300.306, before the initial provision of special education and related services to a child with a disability. 34 CFR §300.301(a). The purpose of the evaluation is to determine whether the child qualifies as a child with a disability and the nature and extent of the educational needs of the child. Under 34 CFR §300.304(b)(1), in conducting the evaluation, the public agency must use a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information about the child that may assist in determining whether the child is a child with a disability and the educational needs of the child. That information could include information from a physician, if determined appropriate, to assess the effect of the child's visual impairment on the child's eligibility and educational needs. However, under 34 CFR §300.304(b)(2), no single measure or assessment may be used as the sole criterion for determining whether the child is a child with a disability and for determining an appropriate educational program for the child.

Under 34 CFR §300.306(c)(1)(i), in interpreting evaluation data for the purpose of determining whether the child is a child with a disability under Part B of the IDEA and the educational needs of the child, the group of qualified professionals and the parent must draw upon information from a variety of sources, including aptitude and achievement tests, parent input, and teacher recommendations, as well as information about the child's physical condition, social or cultural background, and adaptive behavior. Under 34 CFR §300.306(c)(1)(ii), the public agency must ensure that information obtained from all of these sources is documented and carefully considered. There is nothing in the IDEA or the Part B regulations that would prevent a public agency from obtaining a medical diagnosis prior to determining whether the child has a

particular disability, and the educational needs of the child.² Also, there is nothing in the IDEA or the Part B regulations that would prohibit a State from requiring that a medical diagnosis be obtained for purposes of determining whether a child has a particular disability, provided the medical diagnosis is obtained at public expense and at no cost to the parents, and is not used as the sole criterion for determining an appropriate educational program for the child. Further, if a State requires a medical diagnosis consistent with the above criteria, such a requirement exceeds the requirements of Part B of the IDEA. Under 34 CFR §300.199(a)(2), the State would be required to identify in writing to the LEAs located in the State, and to the Secretary, that such rule, regulation, or policy is a State-imposed requirement that is not required by Part B of the IDEA and Federal regulations.

When determining a child's vision status, the LEA's evaluation should be thorough and rigorous. Such evaluations should include a data-based media assessment, be based on a range of learning modalities (including auditory, tactile, and visual), and include a functional visual assessment. In previously-issued guidance, OSEP has noted that an assessment of a child's vision status generally would include the nature and extent of the child's visual impairment and its effect on the child's ability to learn to read, write, do mathematical calculations, and use computers and other assistive technology, as well as the child's ability to be involved in and make progress in the general curriculum offered to nondisabled students. Such an evaluation generally would be closely linked to the assessment of the child's present and future reading and writing objectives, needs, and appropriate reading and writing media. The information obtained through the evaluation generally should be used by the eligibility team in determining whether it would be appropriate to provide a blind or visually impaired child with special education or related services as required by the IDEA. In addition, because the evaluation must assess a child's future needs, a child's current vision status should not necessarily determine whether it would be inappropriate for that child to receive special education and related services while in school. Please see OSEP's Dear Colleague Letter on Braille, June 19, 2013, available at: <http://www2.ed.gov/policy/speced/guid/idea/memosdcltrs/brailledcl-6-19-13.pdf>.

You may wish to consult the following outside resources that address assessments for children who have, or are suspected of having a "visual impairment including blindness."³

- American Foundation for the Blind. Assessments for students who are blind or visually impaired. Retrieved from <http://www.familyconnect.org/info/education/assessments/13>
- American Printing House for the Blind, Inc. Accessible tests resource center. Retrieved from <http://www.aph.org/accessible-tests/>

² In the case of a suspected "visual impairment including blindness," a diagnosis may be made by a medical professional such as the child's pediatrician, ophthalmologist, or optometrist.

³ These organizations are examples of organizations that may be helpful on these matters. We cannot vouch for the quality or completeness of their assistance. They are provided merely as examples, and there may be other organizations that you may wish to consult.

- Perkins eLearning Center. Assessment of students who are blind or visually impaired. Retrieved from <http://www.perkinselearning.org/scout/assessment-students-who-are-blind-or-visually-impaired>

Based on the guidance set forth in this memorandum and OSEP's *Letter to Kotler*, a State may need to review its criteria and revise those criteria, as appropriate, and make sure that its LEAs are informed of the changes. As an example of how a State could revise its criteria, a State could comply with the IDEA requirements by adding a general criterion stating that the definition of "visual impairment including blindness" includes, in addition to other specific State-established criteria, any other impairment in vision that, even with correction, adversely affects a child's educational performance.

OSEP will be following up with States through our various monitoring activities. If you have questions or would like to access technical assistance, please contact your OSEP State Lead. We appreciate your continued efforts to ensure that children suspected of having visual impairments including blindness are provided with an appropriate evaluation and if found eligible under IDEA, the services necessary to meet their special education needs.

cc: Parent Training and Information Centers
OSEP-Funded Technical Assistance Centers



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August 25, 2017

MEMORANDUM

TO: Superintendents and Charter Heads
LEA Special Education Directors
Director of Division of Visually Impaired

From: Mary Ann Mieczkowski
Director of Exceptional Children Resources

Re: Immediate Changes for Eligibility Determinations for Children Suspected of Having a Visual Impairment Including Blindness under the Individuals with Disabilities Education Act (IDEA)

Upon reviewing our State regulations for compliance with federal IDEA regulations, we have realized that a change is necessary. Beginning today, please use the IDEA definition under **34 CFR §300.8(c) (13)** when determining eligibility for visual impairment including blindness:

“Visual impairment including blindness” means an impairment in vision that, even with correction, adversely affects a child’s educational performance.

The Office of Special Education Programs (OSEP) issued two communications regarding eligibility criteria for students suspected of having a visual impairment including blindness. In its November 12, 2014 letter, OSEP explains while states may establish standards for eligibility for special education and related services, they are not required to use the precise definition of disability terms in IDEA. However, the state-established standard must not narrow the definition in IDEA. Under 34 CFR §300.8(c) (13), “visual impairment including blindness” means an impairment in vision that, even with correction, adversely affects a child’s educational performance. In other words, *any* impairment in vision, regardless of severity, is covered, provided that such impairment, even with correction, adversely affects a child’s educational performance.

Furthermore, OSEP states in this letter, the evaluation of vision status and the need for special education and related services should be **thorough and rigorous**, include a data-based media



DEPARTMENT OF EDUCATION

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assessment, be based on a range of learning modalities, including auditory, tactile, and visual, and include a functional visual assessment. An assessment of a child's vision status generally would include the nature and extent of the child's visual impairment, and its affect, for example, on the child's ability to learn to read, write, do mathematical calculations, and use computers and other assistive technology, as well as the child's ability to be involved in and make progress in the general curriculum offered to nondisabled students. Such an evaluation generally would be closely linked to the assessment of the child's present and future reading and writing objectives, needs, and appropriate reading and writing media. The information obtained through the evaluation generally should be used by the IEP Team in determining whether it would be appropriate to provide a blind or visually impaired child with special education instruction or related services as required by the IDEA. In addition, because the evaluation must assess a child's future needs, a child's current vision status should not necessarily determine whether it would be inappropriate for that child to receive special education and related services while in school.

On May 22, 2017, OSEP issued a Memorandum in response to a request for written guidance to assist the state educational agencies in supporting their local educational agencies in reaching appropriate eligibility determinations for children with a visual impairment including blindness disability. The memorandum was issued to ensure broad dissemination of the key points made in the November 12, 2014 letter, to provide the additional guidance requested, and to identify resources that might be helpful to the States as they examine their procedures relating to the identification and evaluation of children suspected of having a visual impairment including blindness.

Both OSEP communications, dated November 12, 2014 and May 22, 2017, state that States may not use criteria or other definitions for "visual impairment including blindness" that result in the exclusion of children who otherwise meet the definition in 34 CFR §300.8(c)(13).

We will be submitting the change to Title 14 Education Delaware Administrative Code this fall and will notify you of the change.

Attachments:

1. OSEP letter of November 12, 2014
2. OSEP Memo of May 22, 2017



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
Margaret M. O'Neill Bldg., Suite 1, Room 311
410 Federal Street
Dover, Delaware 19901
302-739-3621

The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: September 28, 2017

TO: Ms. Leslie W. Ledogar, Regulatory Specialist
Department of Insurance

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 21 DE Reg. 196 [Department of Insurance Arbitration of Health Insurance Disputes Between
Individuals and Carriers Regulation (9/1/17)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Insurance's proposal to amend its regulations covering the arbitration process which enables covered persons to contest adverse insurer decisions. This proposed regulation was published as 20 DE Reg. 196 in the September 1, 2017 issue of the Register of Regulations.

As background, State-regulated health insurers must participate in a Department of Insurance-sponsored arbitration system consistent with 18 DE Admin Code Part 1315. The proposed amendments are intended to implement H.B. No. 100 which was enacted earlier this year. That legislation authorizes the Attorney General's Office, through employees or contractors, to represent individuals contesting adverse insurer decisions involving substance abuse treatment. The Attorney General's Office issued a second RFQ in August soliciting private attorney applications to provide legal assistance in this context. Issuance of the initial RFQ apparently did not result in viable applications.

The proposed regulation is limited in scope. Apart from some formatting changes, its principal revision is the addition of an explicit authorization for an Attorney General's representative to qualify as an "authorized representative":

In cases involving the existence or scope of private or public coverage for substance abuse treatment, an attorney retained or employed by the Delaware Department of Justice may serve as an authorized

representative, regardless of whether the covered person has been determined by a physician to be incapable of assigning the right or representation. The Department of Justice may be reached by calling 302-577-4206.

Section 2.0.

SCPD has the following observations.

First, although H.B. No. 100 (lines 37-38) and the current RFQ contemplate retention of attorneys to represent individuals in substance abuse insurance disputes, it may be preferable to not categorically limit DOJ assistance to attorneys. For example, non-attorney family members and providers are included in the scope of “authorized representatives” in the current regulation. Non-attorney representation in grievance procedures prior to arbitration is also contemplated by Department of Insurance regulation. See 18 DE Reg. 1301.2.0, definition of “authorized representative”. It would therefore be anomalous to limit DOJ assistance solely to attorneys. The Department could consider inserting the following underlined sentence to the proposed revision to §2.0:

In cases involving the existence or scope of private or public coverage for substance abuse treatment, an attorney retained or employed by the Delaware Department of Justice may serve as an authorized representative, regardless of whether the covered person has been determined by a physician to be incapable of assigning the right of representation. Such attorney may authorize an expert to act on the attorney’s behalf in arbitration proceedings within the scope of this regulation. The Department of Justice may be reached by calling 302-577-4206.¹

The addition of the sentence would clarify that the DOJ can utilize substance abuse experts to represent covered persons in arbitration proceedings. Cf. §2.0, definition of “provider” which lists several types of experts who could be well qualified to present arbitration cases on behalf of a covered person.

Second, the Department should consider providing a specific DOJ website address (with description of its substance abuse legal assistance program) in addition to a phone number.

Third, H.B. No. 100 can only be effective if covered persons denied substance abuse treatment receive timely and prominent notice of the availability of DOJ assistance. The Department of Insurance is charged with developing the language in such notices (lines 51-53). Unfortunately, this arbitration regulation omits any reference to such notice and does not otherwise inform persons of the availability of such assistance. At a minimum, the Department should consider adding a provision notifying an aggrieved person contesting denial of substance abuse treatment of possible DOJ assistance in §3.14 and §3.5

The SCPD is endorsing the proposed regulation subject to the above recommended revisions.

¹H.B. No. 100 (line 24) contemplates the use of “experts” in substance abuse insurance disputes. The term “expert” is not defined and could encompass professionals in the field of addiction who, under attorney supervision, could appear on a covered person’s behalf in arbitration proceedings authorized by 18 DE Admin Code Part 1315.

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

cc: The Honorable Matthew Denn, Attorney General
Mr. Jim Martin, Chair-DSAMH Advisory Council
Ms. Barbara Messick, Chair-DPBHS Advisory Council
The Honorable Helene Keeley
The Honorable Margaret Rose Henry
The Honorable Stephanie Hansen
The Honorable Anthony Delcollo
The Honorable Dave Lawson
The Honorable Michael Mulrooney
The Honorable Ruth Briggs King
The Honorable Timothy Dukes
Mr. Christian Wright, DAG
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

21reg196 dept of insurance arbitration of health insurance disputes 9-27-17



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STATE COUNCIL FOR PERSONS WITH DISABILITIES
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The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: September 28, 2017

TO: Ms. Leslie W. Ledogar, Regulatory Specialist
Department of Insurance

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 21 DE Reg. 192 [Department of Insurance Health Insurance Claim Review Reg. [21
DE Reg. 192 (9/1/17)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Insurance's proposal to amend its regulations covering the internal review and utilization review processes which enable covered persons to contest adverse insurer decisions. This proposed regulation was published as 20 DE Reg. 192 in the September 1, 2017 issue of the Register of Regulations. This proposed regulation (amending Part 1301) complements the other proposed regulation (amending Part 1315).

As background, State-regulated health insurers must participate in a Department of Insurance-regulated internal review and utilization review system consistent with 18 DE Admin Code Part 1301. The proposed amendments are intended to implement H.B. No. 100 which was enacted earlier this year. That legislation authorizes the Attorney General's Office, through employees or contractors, to represent individuals contesting adverse insurer decisions involving substance abuse treatment. The Attorney General's Office issued a second RFQ in August soliciting private attorney applications to provide legal assistance in this context. Issuance of the initial RFQ apparently did not result in viable applications. H.B. No. 100 (lines 51-53) also requires the Department of Insurance to ensure notice to covered persons of the availability of DOJ assistance.

The SCPD has the following observations.

First, although H.B. No. 100 (lines 37-38) and the current RFQ contemplate retention of attorneys to represent individuals in substance abuse insurance disputes, it may be preferable to not categorically limit

DOJ assistance to attorneys. For example, non-attorney family members and providers are included in the scope of “authorized representatives” in the current regulation. See 18 DE Reg. 1301.2.0, definition of “authorized representative”. It would therefore be anomalous to limit DOJ assistance solely to attorneys. The Department could consider inserting the following underlined sentence to the proposed revision to §2.0:

In cases involving the existence or scope of private or public coverage for substance abuse treatment, an attorney retained or employed by the Delaware Department of Justice may serve as an authorized representative, regardless of whether the covered person has been determined by a physician to be incapable of assigning the right of representation. Such attorney may authorize an expert to act on the attorney’s behalf in proceedings within the scope of this regulation. The Department of Justice may be reached by calling 302-577-4206.¹

The addition of the sentence would clarify that the DOJ could utilize substance abuse experts to represent covered persons in mediation (§4.0), IHCAP (§5.0), and expedited IHCAP (§6.0) proceedings. Cf. §2.0, definition of “provider” which lists several types of experts who could be well qualified to present cases on behalf of a covered person. This option would preserve DOJ resources by allowing the DOJ to send an expert to a mediation proceeding in lieu of an attorney.

Second, the Department should consider providing a specific DOJ website address (with description of its substance abuse legal assistance program) in addition to a phone number.

Third, the Department should reconsider the proposed notice of DOJ assistance in §4.0. Consider the following:

A. The notice is “buried in the boilerplate” and not prominent. To fulfill the spirit of H.B. No. 100, the Department could consider a separate heading (e.g., “Substance Abuse Treatment Denials: Special Assistance”) followed by a brief explanation and DOJ contact information (website and phone number).

B. The notice only informs an aggrieved person of the availability of DOJ assistance with mediation. See §4.0. This is misleading since DOJ assistance is also available in the internal review process (§3.0), IHCAP procedure (§5.0), and expedited IHCAP procedure (§6.0). Apart from carrier notice of the availability of DOJ assistance in contexts other than mediation, the Department could consider including a notice of DOJ assistance as a complement to the notice in §5.4.

C. The proposed notice indicates that DOJ assistance is only available if “you are approaching the deadline for filing your appeal”. This limitation is not authorized by law and will deter requests for DOJ assistance.

D. To encourage individuals to consider DOJ assistance, it would be preferable to clarify that DOJ assistance is “free”. This could be easily accomplished by revising the relevant language to “...receive free legal assistance”.

¹H.B. No. 100 (line 24) contemplates the use of “experts” in substance abuse insurance disputes. The term “expert” is not defined and could encompass professionals in the field of addiction who, under attorney supervision, could appear on a covered person’s behalf in proceedings authorized by 18 DE Admin Code Part 1301.

The SCPD is endorsing the regulation subject to the above recommended revisions.

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

- cc: The Honorable Matthew Denn, Attorney General
Mr. Jim Martin, Chair-DSAMH Advisory Council
Ms. Barbara Messick, Chair-DPBHS Advisory Council
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