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September 16, 2011

Ms. Rosanne Mahaney, Director
Division of Medicaid & Medical Assistance
Lewis Building
Herman Holloway Campus
1901 N. DuPont Highway
New Castle, DE 19720

RE: DMMA Draft PDN Provider Specific Policy

Dear Ms. Mahaney:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMAs) draft private duty nursing (PDN) regulation. SCPD certainly appreciates the opportunity to comment and apologizes for the delay in providing the commentary to the Division.

As background, in 2005 Department of Health and Social Services (DHSS) issued a comprehensive regulation addressing Medicaid coverage of PDN services. SCPD, the Developmental Disabilities Council (DDC), and the Governor's Advisory Council for Exceptional Citizens (GACEC) submitted extensive comments which prompted several amendments. However, there remained some contexts of concern to the Councils, including weekly caps on PDN hours (8 hours for adults and 16 hours for children); and bar on "banking" or "carrying over" hours. In May of 2009, the Disabilities Law Program (DLP) challenged the no-exceptions 8-hour cap on PDN on behalf of a twenty-nine year old with Duchenne muscular dystrophy with a peg feeding tube and tracheotomy with a primary diagnosis of ventilator dependent respiratory failure. A DMMA hearing officer upheld the no-exceptions 8-hour cap on PDN irrespective of need. The DLP appealed that decision to Superior Court. Consistent with the attached article, the application of such caps is a national problem which has prompted litigation in other states. A common scenario is an individual receiving 16 hours of PDN under the children's cap being threatened with institutionalization when reaching age 21 in states with no or reduced PDN for adults.

In August, 2009, Council and DLP representatives met with DHSS representatives to review concerns with limited access to PDN. An informal agreement was reached to interpret an existing regulation as authorizing an exception to the 8-hour PDN cap for adults:

5.3.3: An increase in hours may be approved if additional hours will avoid hospitalization or institutional placement as a cost effective measure. This will depend on the medical necessity, the amount of additional hours needed and the letter of medical necessity from the admitting physician.

This interpretation was an interim approach pending development of revised regulations. In practice, technologically dependent adult Medicaid beneficiaries are currently provided more than 8 hours of PDN if necessary to avoid institutionalization based on that regulation. Given the change in practice, the DLP withdrew its appeal of the adverse hearing officer decision. In the Fall of 2009, DMMA established a work group to undertake a comprehensive revision to its PDN standards and the Division then shared the draft standards in November 2010. SCPD is now providing the following analysis of the draft regulations.

§§1.0 and 5.1: The "Overview" section includes a salutary provision requiring MCOs to provide PDN consistent with the policy. However, MCOs were historically responsible only for the first 28 hours of PDN per week. See 8 DE Reg. 1303, 1306, Section 1.0 (March 1, 2005). This limit is absent from the policy. Perhaps it has been superseded by changes in the Diamond State Health Plan Plus (DSHPP). Moreover, §5.1 contemplates DSAAPD or DMMA nursing approval of PDN exclusively rather than an MCO nurse. The policy does not address MCO authorization of PDN. The current responsibility of MCOs should be clarified in the contexts of number of hours and authorization. In a similar context, the policy covers PDN covered under the E&D waiver. See §5.1.1.1. Normally, a waiver has its own utilization limits and standards. If the waiver standards differ from the draft policy, they will have to be reconciled to conform.

§§1.0 and 1.1.1: These sections convey inconsistent messages. On the one hand, §1.1.1 establishes a PDN cap of 16 hours for children under age 21. On the other hand, §1.0 recites that such limits are ignored if more services are medically necessary. Under the Medicaid program, all services must be medically necessary. This approach is confusing and will predictably lead to disparities in application of the policy. DMMA could consider the following alternative approaches. First, it could simply delete the 16-hour cap in §1.1.1. Second, since relatively few children will need more than 16 hours of PDN, consider the following:

> 1.1.1. Children under age 21 are eligible for up to sixteen hours of PDN daily. This presumptive limit is subject to exception based on either:
>
> 1.1.1.1 meeting the criteria of §1.1.5;
> 1.1.1.2 meeting the criteria of §5.2.3;
> 1.1.1.3 meeting the criteria of 5.2.6; or
> 1.1.1.4 based on compelling justification, securing the written approval of the Medicaid Director or designee.

The addition of §1.1.1.4 provides some additional flexibility to DMMA since compelling circumstances apart from institutionalization could arise (e.g. sudden, temporary, unexpected illness or injury of caregiver). The addition of §1.1.1.2 clarifies the interplay between §5.2.3 and this section.

§§1.1.2 and 5.2.3 and 5.2.6:

A. The 2009 hearing officer decision opined that the (currently renumbered) §1.1.5 did not apply to adults. It is therefore critical to clarify DMMA's regulatory intention that §1.1.5 does authorize an exception to the 8-hour adult limit in §1.1.2.

B. It is important to clarify that §1.1.3 is an exception to §1.1.2.

C. The rationale for the exception in §5.2.3 would logically apply to both caregivers of children and adults. Therefore, §5.2.3 should be amended by substituting "individual" for "child".

D. The rationale for the exception in §5.2.6 would also apply to adult day programs. Section 5.2.6 should be revised to include adults unable to attend a day program due to sickness, closure, or inclement weather.

Similar to the above recommended children's standard, SCPD recommends amending §1.1.2 as follows:

> 1.1.2. Adult Medicaid clients age 21 and over are eligible for up to eight hours of PDN daily. This presumptive limit is subject to exception based on either:
> 1.1.2.1 meeting the criteria of §1.1.3;
> 1.1.2.2 meeting the criteria of §1.1.5;
> 1.1.2.3 meeting the criteria of §5.2.3;
> 1.1.2.4 meeting the criteria of §5.2.6; or
> 1.1.2.5 based on compelling justification, securing the written approval of the Medicaid Director or designee.

§1.1.3.2: SCPD realizes it does not have an expertise in this area; however, the proposed DMMA policy is ostensibly "underinclusive" in the context of technology dependency and too strict in addressing tracheostomy needs. The attached Washington State policy, for example, includes consideration of "complex respiratory support" apart from a tracheotomy, including "application of respiratory vests" and "intermittent positive pressure breathing" which do not appear within the DMMA policy. Moreover, the DMMA policy requires that all 6 bullets under this subsection be met. Thus, if someone needed suctioning every hour (6th bullet) but only needed nebulizer treatments 3 times a day, the person would not qualify for more than 8 hours of PDN. Likewise, the DMMA policy does not address intravenous/parenteral administration of medications or nutritional substances on a continuing or frequent basis in contrast to the Washington State policy.

§1.1.5: The reference to "admitting" should be deleted. PDN is not provided within facilities. See §1.1.6.

§5.1.4: This subsection categorically precludes all "banking" or "carryover" of hours not used in one day. DHSS has been adopting more flexible standards in similar programs. For example, the DHSS Personal Attendant Services (PAS) program allows flexibility in use of hours within the same pay period. The attached PAS Service Specifications recite as follows:

4.11 The use of flexed hours within the same time period is permitted. No hours can be "borrowed" or "advanced" in anticipation of paying them back through flexing at a later date.
4.12 Additional short term attendant services hours may be authorized for consumers if determined eligible by the DSAAPD Case Manager.

[emphasis supplied]. It would be preferable for the PDN standards to incorporate a similar approach.

In their 2005 comments on the previously numbered subsection, the Councils commented as follows:

> (T)he regulations are unduly constrictive in the context of "carryover". See Sections 5.1.5 and 5.2.9. The standards explicitly disallow carryover even to the next day. A completely rigid and inflexible system is simply not realistic and will result in hardship to families. Recognizing that a weekly schedule is developed at a minimum, consider the following alternative to Section 5.2.9:
>
> > DSS projects a sufficient number of hours per day. If the hours authorized are not used on a particular day, the hours do not generally carryover to the next day or weekend nor can the hours be "banked" to be used at a later time. Occasional variations of 3 hours or less within a week based on unexpected or extenuating circumstances may be acceptable.

8 DE Reg. 1303, 1305. Consistent with the above commentary, DMMA could revise the proposed §5.1.4 as follows:

> 5.1.4. PDN hours must be used for the period of time in which they are authorized. If the hours authorized are not used on a particular day, the hours do not generally carry over to the next day or weekend nor can the hours be "banked" to be used at a later time. Occasional variations of 3 hours or less within a week based on unexpected or extenuating circumstances may be approved.

§5.2.1: In the second sentence, SCPD believes DMMA intended to insert the word "for" between "responsibility" and "the". However, there is some "tension" between a requirement of a "capable" caregiver and the ADA. There may be caregivers who are elderly or insufficiently capable/sophisticated to provide technical or physical care. They may not be able to physically lift a Medicaid patient due to their own disability. However, they may have the wherewithal to supervise the provision of care. Query whether a no-exceptions policy of caregiver capacity may violate the "reasonable accommodations" provisions of the ADA.

§5.2.4: SCPD recommends adding the following sentence: "The consent of the child's parent or guardian is required to authorize school-related PDN." Under the IDEA, schools cannot force parents to use public or private insurance to provide a FAPE and must obtain parental consent to access a child's Medicaid. See attached OSEP Policy Letter to Dr. O. Spann, 20 IDELR 627

(September 10, 1993). There may be parent-school "conflict" situations in which DHSS or an MCO authorizes only a limited number of PDN hours and the school wishes to "take" a disproportionate share of the overall approved hours. In the event of a disagreement, the parent/guardian's decision prevails over the school's wishes.

§5.2.5: Consistent with the discussion of §5.2.1 above, there may be circumstances in which a parent/caregiver is not capable of independently transporting a child to and from medical appointments. For example, there may be technology at home to assist the parent/caregiver in providing care which is not available in-transit. Alternatively, a parent may be capable of suctioning a stable child in bed but be unable to suction the same child in a moving vehicle jostling the passengers up and down and side to side. The last two sentences of this subsection are too rigid.

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

Sincerely,

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

cc: Ms. Rita Landgraf
Ms. Debra Gottschalk
Mr. Dave Michalik
Ms. Sharon Summers
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

p&l/regs/dmma pdn reg 9-16-11

CMS, from previous page

CourtWatch Update: Good Decisions for People with Disabilities

In recent months, advocates have been cheered by several positive federal court decisions for people with a variety of disabilities. These victories have been welcome news, considering the mixed success of cases filed to enforce the Americans with Disabilities Act (ADA) in the past several years.

Two similar cases in Illinois and Oklahoma involve young adults with severe physical disabilities. Both received benefits through Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for individuals under age 21. Under EPSDT, children and youth are entitled to all Medicaid services necessary to "correct or ameliorate" their physical and mental disabilities and conditions, regardless of whether those services would be covered for adults 21 and over. In *Radaszewski v. Maram,* Illinois' Medicaid program had covered sixteen hours of in-home nursing services per day for Eric Radaszewski. When he turned 21 and was no longer entitled to EPSDT, his coverage would be reduced to five hours per day. It was undisputed that this reduction would place Eric at imminent risk of institutionalization in a nursing home. Moreover, living in a nursing home would be very dangerous for him because he could not receive the individual attention needed for his condition.

The court held that Illinois' Medicaid agency's refusal to provide the care Eric needed in the community violated the ADA and Section 504 of the Rehabilitation Act. Specifically, forcing him into a nursing home to receive the care that he needed violated the two statutes' requirement that services be provided in the most integrated setting appropriate. The court held that providing care in the community could be reasonably accommodated even taking into account Illinois' resources and the needs of others with disabilities. It noted that the cost of caring for Eric in the community would actually be less than care in a hospital and that the state could request a waiver from the federal government to enable it to provide services in the community. Prairie State Legal Services represents the plaintiff in this case. As of press time, the state had not appealed the decision.

In the Oklahoma case *Easton v. Fogarty,* the plaintiff, Lindsey Easton, has severe physical disabilities as a result of a rare form of muscular dystrophy. As a result, she is ventilator-dependent and needs nursing services around the clock. Despite her severe limitations, however, she was valedictorian of her high school class. She was able to live at home because Oklahoma Medicaid covered 16 hours of nursing services per day through EPSDT. Lindsey and her family were told that the nursing services would be terminated when she turned 21, because Oklahoma did not cover in-home nursing services for adults. Before her birthday, Lindsey sued for violations of the ADA and Section 504's community integration requirements. She also filed for a temporary restraining order to halt the termination of services. Before the court could hear the case, however, the state agreed not to terminate the services while the case was pending. The case will continue. The attorney representing Lindsey is Steven A. Novick of Tulsa.

Federal courts in New York and Florida considered disability discrimination claims on behalf of groups living in nursing homes. In *Joseph S. v. Hogan,* the plaintiffs sued on behalf of individuals with mental illness discharged from psychiatric hospital settings to nursing homes. They claimed that New York was not providing services in the most integrated settings appropriate, in violation of the ADA and Section 504. They also argued that Medicaid provisions governing placement in nursing homes were violated. Attorneys for the state argued that the case should be dismissed, but the court refused to dismiss the ADA and 504 claims. It also held that the Medicaid provisions were enforceable, although it dismissed some Medicaid claims based on events that happened too far in the past.

The analysis and decision in this case were made by a magistrate judge and were adopted by the district court judge on May 23. The case will continue. Disability Advocates, Inc., Schiff Hardin, New York Lawyers in the Public Interest, and Mental Hygiene Legal Services are counsel for the plaintiffs.

Long v. Benson was filed in federal court in Florida on behalf of people living in nursing homes who are capable of and wish to live in the community. These people's disabilities are not severe and could live safely in their homes

or community settings with appropriate supportive services. Thus, forcing them to live in nursing homes to receive services violates the ADA and Section 504. Attorneys for Florida argued that the case should be dismissed because, among other reasons, the regulations requiring that services be provided in the least restrictive setting and that states make reasonable accommodations for people with disabilities were invalid. The court rejected this and all of the state's other arguments and the case will continue. The plaintiffs are represented by Southern Legal Counsel, Steve Gold, AARP Foundation Litigation and the National Health Law Program.

For decisions or pleadings in any of these cases, contact Sarah Somers at somers@healthlaw.org.

WASHINGTON STATE

Eligibility for PDN Services
Who determines eligibility for PDN?

- For HCS clients, the Community Nurse Consultant determines eligibility for PDN.
- For DDD clients age 18 and older, the Nursing Care Consultant determines eligibility for PDN.

What makes a client eligible for PDN Services?
Clients must meet medical, financial and program eligibility requirements. Financial and program eligibility may be completed concurrently; however, **PDN cannot begin until financial eligibility is established.** (WAC 388-106-1010)

(1) Financial Eligibility: Verify that the client meets financial eligibility requirements, which means the client is Categorically Needy (CN) or Medically Needy (MN). NOTE: A client does not have to participate toward their PDN, but must participate toward personal care depending on their income. In HCS, the financial worker will provide you with the participation information. In DDD, the Case Resource Managers calculates the participation information.

Financial Requirements for PDN clients	
Program	*Requirements*
COPES	The client does not participate toward PDN. The client does participate toward waivered services they are eligible for. Income cannot be above the COPES SIL (Special Income Level)
MPC - CN	The client does not participate toward PDN or any personal care they are eligible to receive. The client does participate toward room and board in an AFH. (A client cannot receive PDN in any other residential setting)
CN / not receiving MPC	The client does not participate toward PDN. The client does participate toward cost of care in an AFH (A client cannot receive PDN in any other residential setting).
MN – Regular	Spend down may be required and the client can use PDN for spend-down, but neither MN nor PDN services can be authorized until spend down is met.
MN – Waiver	The client does not participate toward PDN. The client does participate toward the cost of personal care for in-home and AFH services. (A client cannot receive PDN in any other residential setting.)
CORE Waiver – In-Home	The client does not participate toward PDN.
Basic Plus In Home	The client does not participate toward PDN.

(2) Functional Eligibility: You must complete a face to face CARE assessment every six months. [WAC 388-106-1030 (1)] That assessment and the Skilled Nursing Task Log (SNTL) must verify that the client:

1. Requires care in a hospital or meets Nursing Facility Level of Care;
2. Has unmet skilled nursing needs that cannot be met in a less costly program or restrictive environment; and
3. Is unable or unwilling to have their care tasks provided through nurse delegation, COPES Skilled Nursing, or self-directed care; and
4. Has a complex medical need that requires four or more **continuous** hours of skilled nursing care which can be safely provided outside an institution. (**Note:** The need for a nursing assessment does not qualify a person for PDN); and
5. Is technology-dependent daily, meaning:

Functional Requirements for technology-dependent PDN clients	
Skilled Task	*Description*
A. Mechanical Ventilation	The client requires the use of a mechanical device.
B. Complex respiratory support	Complex respiratory support means that: o The client requires **two** of the following treatment needs at least one time in a four continuous hour period: i. Postural drainage and chest percussion; or ii. Application of respiratory vests; or iii. Nebulizer treatments with or without medications; or iv. ~~Intermittent Positive Pressure~~ Breathing; or v. O2 saturation with treatment decisions dependent on the results; **AND** o The client's treatment needs must be assessed and provided by an RN or LPN; **AND** o The client's treatment needs cannot be nurse delegated or self-directed.
C. Tracheotomy	The client requires sterile suctioning at least one time in a four continuous hour period.
D. Intravenous/parenteral	The client requires intravenous/parenteral administration on a continuing or frequent basis.

administration of multiple medications	
E. Intravenous administration of nutritional substances.	The client requires intravenous administration on a continuing or frequent basis.

6. Requires skilled nursing care that is medically necessary, as defined by the client's physician; and
7. Is able to supervise the care provider(s) or has a guardian who supervises care; and
8. Has family or other appropriate supports who assume a portion of the care; and
9. Does not have other resources or means for providing this service.

Primary care provider approval: Have a primary provider document in the PDN provider's plan of care:

- The client's medical stability;
- The client's appropriateness for PDN care;
- Approval of the PDN provider's plan of care; and
- Orders for medical services.

SERVICE SPECIFICATIONS #X
Revised 4/24/09

PERSONAL ATTENDANT SERVICES

1.0 SERVICE DEFINITION

1.1 Personal Attendant Services (PAS) provides support to adults with physical disabilities who require assistance with the functions of daily living, self-care or mobility in order to maximize their independence in the community. This service relies on the consumer's ability to self direct.

1.2 A consumer may act through a guardian or appointed representative.

1.2.1 The guardian or appointed representative for the consumer may not be hired as his/her personal attendant.

1.3 The consumer shall be supported in his/her effort to direct services contained in the consumer's Individual Services Plan (ISP) as outlined in the specifications.

2.0 SERVICE UNIT

2.1 The standard service unit is one hour of service provided by an attendant to an eligible consumer.

2.2 The minimum billable unit of time is one quarter hour of service.

2.3 Travel to and from the consumer's home (or initial service site) shall not be included.

3.0 ELIGIBILITY

3.1 The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) Case Manager will determine consumer eligibility for PAS and approve the amount of weekly units authorized for service. Approval will be based upon needs and proposed usage of the attendant(s). The DSAAPD Case Manager and consumer will jointly determine the units required.

3.2 Criteria that the DSAAPD Case Manager will use to determine consumer eligibility include, but are not limited to, the following:

3.2.1 residency in the State of Delaware

3.2.2 age 18 years or older

3.2.3 presence of a severe, chronic physical disability which precludes or significantly impairs the individual's independent performance of essential activities of daily living, self-care or mobility within home or community environments. For purposes of this section, a "chronic disability" is a medically determinable impairment which can be expected to last for a continuous period of not less than 12 months.

4.0 SERVICE STANDARDS

4.1 The provider agency must meet and comply with all applicable federal, state and local rules, regulations and standards applying to the services being provided.

4.2 Within 45 working days of referral, the provider agency and the consumer shall negotiate and sign an Individual Service Plan (ISP) based the consumer's needs, proposed usage of the attendant(s) and the units of service as determined by the consumer and DSAAPD during the eligibility determination.

4.3 The ISP shall contain the following:

- 4.3.1 for the initial ISP, goals for service, as developed between the DSAAPD Case Manager and consumer and as defined on the Service Referral Form.
- 4.3.2 a description of the services to be provided and how they will be provided;
- 4.3.3 the time and number of service units (hours) to be delivered
- 4.3.4 a description of priority care and the viable back-up plan.
- 4.3.5 a section showing the following:
  - 4.3.5.1 Name and the relationship of the regular attendant(s) and the backup attendant(s).
  - 4.3.5.2 Name, relationship, and notation of other paid or unpaid support persons in the home
  - 4.3.5.3 Number of hours scheduled per pay period;
  - 4.3.5.4 Listing of other employment obligations of attendant(s) or backup attendant(s).
  - 4.3.5.5 Any unique circumstances or conditions;
- 4.3.6 confirmation of the completion of attendant and/or consumer training;
- 4.3.7 a clearly stated description of the responsibilities of the provider agency, the attendant(s) and the consumer.

4.4 This ISP must be submitted to the DSAAPD Case Manager within 10 working days of signature

4.5 **Provider Agency Responsibilities:**

- 4.5.1 Recruit attendants
  - 4.5.1.1 Provide basic training for attendants
  - 4.5.1.2 Maintain a roster of available attendants for the consumer to enable freedom of choice.
  - 4.5.1.3 Secure background checks including the Adult Abuse Registry on all attendants, including relatives and backup attendants
- 4.5.2 Provide technical assistance to consumers about the employment process including, but not limited to:
  - 4.5.2.1 Assisting consumer in the purchasing of Workers Compensation Insurance policies
  - 4.5.2.2 Securing and maintaining a checking account to be used for payroll related items

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

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

4.5.3 The provider agency is obligated to meet the following monitoring requirements:

4.5.3.1 Monitor units used by consumers on a monthly basis; ensuring attendants do not exceed the number of units authorized by DSAAPD staff, including an appropriate use of flexed hours;

4.5.3.2 Monitor time sheets to ensure they are submitted in a timely fashion and accurately reflect the hours and duties worked by the attendant;

4.5.3.3 Conduct reviews on at least quarterly basis for the health, safety, and welfare status of the individual consumer and submit quarterly progress reports to the individual DSAAPD case manager;

4.5.3.4 Conduct face-to-face visits with the consumer at least annually but more often as the consumer's needs indicate;

4.5.3.5 Review and update the ISP during the annual face-to-face visit;

4.5.3.6 Mail an annual satisfaction survey to consumers and supply DSAAPD with the results, including all comments as written in the surveys.

4.5.3.7 Monitor that duties outlined in the ISP are in compliance with Child Labor Laws and related rules and policies, whenever applicable;

4.5.3.8 The agency is obligated to the following additional requirements when consumers elect to use family members as paid service providers:

4.5.3.8.1 When the paid service provider is a family member, conduct face-to-face visits with the consumer on at least a semi-annual basis.

4.5.4 The provider agency is obligated to meet the following administrative requirements:

4.5.4.1 The provider agency must establish contact within five (5) working days of referral from DSAAPD

4.5.4.2 The provider agency must perform the initial home visit within five (5) working days of establishing contact.

4.5.4.2.1 If a home visit cannot be conducted within five (5) working days, the

DSAAPD CSP Case Manager must be notified

4.5.4.3 The provider agency must notify the DSAAPD CSP Case Manager, and the consumer in writing, within ten (10) working days of the home visit, when the provider is unable to serve the consumer. The written notice shall include the reason the provider is unable to serve the consumer.

4.5.4.4 If the consumer fails to establish service within 45 working days of the referral, DSAAPD will be notified. DSAAPD will then assess the reason for lack of initiation of service which may be followed by notice of intent to terminate eligibility.

4.5.4.5 The provider agency must establish the capability to respond to priority care emergencies. For this purpose, the use of subcontractors for emergency care is permitted.

4.5.4.5.1 The provider agency is not required to obtain background checks on attendants used for emergency backup

4.5.4.5.2 Emergency backup is defined as service provided for one week or less, when neither the regular attendant or backup attendant is available

4.5.4.6. For each consumer, the provider agency shall establish and maintain a case file, which includes the following:

4.5.4.6.1 The Service Referral Form from DSAAPD;

4.5.4.6.2 The ISP signed by the consumer and the provider agency;

4.5.4.6.3 Documentation of the consumer and attendant(s) training activities;

4.5.4.6.4 Documentation of any problems or concerns raised by the consumer, attendant(s) or other third party; the attempts to investigate the problem or concern; and disposition of the problem;

4.5.4.6.5 Documentation of the annual reassessments of the ISP; and

4.5.4.6.6 Documentation of all in-home visits and telephone contacts;

4.5.4.6.7 Signed documentation that the provider has discussed appropriate

employee/employer relationships and behaviors with the consumer

4.5.4.7 The provider agency will make a reasonable effort to confer with DSAAPD to resolve problems that threaten the continuity of the consumer's attendant services.

4.5.4.8 The provider agency may request permission of DSAAPD to reduce or terminate service when in the agency's professional judgment, one of the following occurs:

4.5.4.8.1 The consumer no longer needs the service or level of service currently being provided;

4.5.4.8.2 The consumer needs a level of service that is beyond the scope and purpose of the attendant service program;

4.5.4.8.3 The consumer's uncooperative behavior, abuse, misuse of the service or program;

4.5.4.8.4 The unsafe and/or unsanitary conditions or activities in the consumer's place of residence, even though services are provided and listed on the ISP, jeopardizes the safety or health of attendant(s) and/or the provider agency's staff;

4.5.4.8.5 The involvement of the consumer in illegal activities;

4.5.4.8.6 The consumer submits timesheets for services not provided or for hours not worked by an attendant(s) or otherwise tries to defraud the program;

4.5.4.8.7 The consumer does not pay the co-pay in accordance with the payment schedule mutually agreed upon by the consumer, agency and DSAAPD.

4.5.4.8.8 The consumer fails to cooperate with the provider in filing the appropriate tax forms (Schedule H).

4.5.4.9 The provider agency must ensure access to authorized representatives of Delaware Health and Social Services to the participant's case files and medical records.

4.5.4.10 The provider agency must maintain the consumer's right of privacy and confidentiality

4.5.4.11 The provider agency must comply with DSAAPD quality assurance initiatives related to this program

4.5.4.12 The provider agency must establish policies and procedures related to the resolution of consumer complaints and grievances.

4.5.4.13 The provider agency must include a written procedure of how unresolved complaints or grievances will be communicated to DSAAPD.

4.6 Consumer responsibilities:

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

4.6.1.1 Conduct hiring interviews for attendants.

4.6.1.2 Supervise and direct attendant in job functions

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

4.6.1.4 Maintain acceptable documentation for payroll and tax filing

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

4.6.2 Consumer may accept or reject attendants referred to them by a provider agency

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

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

4.7 Allowable Activities

4.7.1 Basic services performed by the attendant(s) include:

4.7.1.1 Assistance with transferring to and from a bed, wheelchair, vehicle, or other environmental setting;

4.7.1.2 Help with use of medical and non-medical equipment, devices, or assistive technology;

4.7.1.3 Assistance with routine bodily functions, including, but not limited to:

4.7.1.3.1 Health maintenance activities;

4.7.1.3.2 Bathing and personal hygiene;
4.7.1.3.3 Bowel or urinary evacuation;
4.7.1.3.4 Dressing and grooming; and
4.7.1.3.5 Food consumption, preparation and cleanup;

4.7.2 Ancillary services may also be provided, but only if the consumer is also receiving one of the above basic services. Ancillary services include:
4.7.2.1 Homemaker-type services, including cleaning, laundry, shopping and seasonal chores;
4.7.2.2 Companion-type services, including transportation, escort and facilitation of written, oral and electronic communication;
4.7.2.3 Assistance with cognitive tasks, including bill payment and money management, planning activities and decision-making.

4.7.3 Attendants may accompany consumers on vacation or other temporary stays away from home. However, attendant service program funds will **not** be allowed to cover any of the costs associated with the travel for the consumer or the attendant(s). The roles and responsibilities of the attendant(s) and the consumer are the same as when at home.

4.8 **Prohibited Activities:**
4.8.1 PAS may not be provided in a long term care facility, acute care facility; or group home except:
4.8.1.1 With prior authorization from DSAAPD Case Manager, PAS may be provided in an acute care setting for no longer than 10 calendar days.

4.9 Employees must be age 18 or above
4.9.1 The hiring of a minor may be considered on a case-by-case basis and prior approval by DSAAPD is required.
4.9.1.1 The employment of a minor employee is subject to Child Labor Laws and related rules and policies.
4.9.1.2 *Care must be exercised if service is provided by a minor, as they are limited to hours and times they are permitted to work, as outlined in Child Labor Laws and related rules and policies.*

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

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

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

6.0 INVOICING REQUIREMENTS

6.1 The providers will invoice DSAAPD pursuant to the DSAAPD Policy Manual for Contracts

6.2 The following information will also be included on the invoices:

- 6.2.1 Consumer name
- 6.2.2 Authorized Hours
- 6.2.3 Hours utilized
- 6.2.4 Monthly Worker's Compensation billed
- 6.2.5 Monthly Criminal Background checks billed

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Digest of Inquiry
(May 13, 1993)

- Is it appropriate for a public agency to bill the costs of special education services to Medicaid or any other third party insurer?

- Before engaging in third party billing for special education services, must a public agency seek parental permission and inform parents of all of their rights in the process?

1055-520X/94/$2+$1.50.

Digest of Response
(September 10, 1993)

Insurance Billing Must be Voluntary if Threat of Financial Loss Exists

Public agencies may access parent's insurance, including Medicaid, to pay for necessary special education services in circumstances where the parents would incur no realistic threat of a financial loss. However, if a realistic threat of financial loss would occur from third party billing, use of parental insurance proceeds to pay for special education services must be voluntary.

Insurance Billing Requires Parental Consent

Public agencies must obtain parental consent to file an insurance claim for special education services and must inform parents of any potential financial losses that they could incur. However, public agencies may not condition provision of necessary special education services on parental consent to filing of an insurance claim, and parents may refuse to sign a consent form without jeopardizing their child's receipt of services.

Text of Inquiry

South Carolina is in the process of implementing a program to provide reimbursement through Medicaid for certain health-related services provided by school districts for children with disabilities. Representatives of the pilot projects are requesting guidance regarding appropriate procedures for dealing with third party insurance.

It is our understanding that Medicaid is the payor of last resort. This means, of course, that Medicaid will not provide reimbursement for expenses that a third party, such as a private insurance company, is legally obligated to pay. School districts are being told by the South Carolina Health and Human Services Finance Commission (the designated state agency responsible for the Medicaid program) that they should attempt to obtain voluntary permission from the parents to bill for Medicaid-reimbursable services. Then, if the parents' insurance policy does not pay for the service, the school district can bill Medicaid.

We are concerned that school districts may encounter future problems if they bill for third party insurance, even if they have prior approval from the parents. Since all services to children with disabilities are mandated to be provided at no cost to the parents, the concern is that a lawsuit could be filed by the parents a number of years later stating that they did not truly realize the long-term implications of permitting their insurance to pay for services to their children. We understand that, in accordance with the Interpretation of Part B of the Education of the Handicapped Act and Section 504 of the Rehabilitation Act (December 30, 1980), a school district may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of children with disabilities would suffer a financial loss.

We are seeking your advice regarding whether it is appropriate and ethical, in your opinion, for school district to bill for third party insurance. Then, in the event it is appropriate for school districts to bill for third party insurance, must they seek the permission of the parents in writing and inform them of all of their rights in the process (including the fact that there may be a potential loss of lifetime benefits). Your assistance in this matter will be very much appreciated. Thank you for your continuing help as we strive to provide appropriate programs for our state's children with disabilities.

Text of Response

I am writing in further response to your letter requesting information regarding the appropriateness of a school district's billing an insurer to pay for services covered under Part B of the Individuals with Disabilities Education Act (Part B). I apologize for the delay in responding.

Specifically, you asked two questions; first, is it appropriate for a school district to bill for third party insurance? Under Part B of the Individuals with Disabilities Education Act (Part B), each State and its local school districts are required to make a free appropriate public education (FAPE) available to children with specified disabilities within the State in mandated age ranges. 34 CFR §§ 300.121 and 300.8. FAPE includes, among other elements, special education and related services, provided at no cost to parents, in conformity with an individualized education program (IEP). In meeting their obligation to provide special education and related services without charge, public agencies "may use whatever State, local, Federal, and private sources of support are available in the State to meet the requirements of this part." 34 CFR § 300.301(a). This regulation also provides that "[n]othing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or pay for services provided to a child with a disability." 34 CFR § 300.301(b).

In December of 1980, the Secretary of Education issued a Notice of Interpretation on Use of Parent's Insurance Proceeds which concluded that:

> The requirements that a free appropriate public education be provided 'without charge' or 'without cost' . . . mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of [children with disabilities] would suffer a financial loss not incurred by similarly situated parents of [nondisabled] children. Financial losses include, but are not limited to, the following:
>
> (1) A decrease in available lifetime coverage or any other benefit under an insurance policy;
>
> (2) An increase in premiums under an insurance policy; or
>
> (3) An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.

45 Fed. Reg. 86390 (Dec. 30, 1980) (copy enclosed).

Therefore, public agencies may access parent's insurance to pay for required special education and related services in

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circumstances where the parents would incur no realistic threat of a financial loss. However, in circumstances where parents would incur a realistic threat of a financial loss, use of parent's insurance proceeds must be voluntary.

In your second question, you asked if the school district must "seek the permission of the parents and inform them of all their rights in the process (including the fact that there may be a potential loss of lifetime benefits)." Public agencies must obtain parental consent for the filing of an insurance claim, including informing parents of any potential financial losses they could incur. However, public agencies may not condition the provision of special education and related services on parental consent to the filing of an insurance claim. Therefore, parents may refuse to sign a consent form without jeopardizing receipt of services to their child.

I hope that the information in this letter is helpful. If this Office can be of further assistance, please let me know.

Patricia J. Guard
Acting Director
Office of Special Education Programs

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