



DISABILITIES LAW PROGRAM

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November 28, 2016

Glyne Williams
DDDS Lifespan Waiver Amendment
Division of Medicaid & Medical Assistance
Planning, Policy & Quality Unit
1901 N. DuPont Hwy.
P.O. Box 906
New Castle, DE 19720-0906

Re: Comments on Lifespan Waiver Amendment

Dear Glyne:

I am submitting the following comments on the Lifespan Waiver Amendment consistent with the DMMA solicitation published at 20 DE Reg. 379 (November 1, 2016).

1. I did not identify any concerns with the following preliminary information. The waiver amendment would be effective on July 1, 2017 (p. 1). The current waiver was approved for a 5-year term effective July 1, 2014 so the amendment would ostensibly be effective for years 4 and 5 (7/1/17 through 6/30/19)(pp. 4, 24, and 186). The waiver remains statewide (pp. 6 and 27). It is open to dual eligibles (Medicaid/Medicare)(p. 5). The level of care remains at an ICF/IID level (pp. 4, 7, 35, and 39). There are no participant co-pays or cost sharing(pp. 184-185). The list of services (pp. 44 and 188) furnished under the waiver is as follows:

- community living supports;
- community participation;
- day habilitation;
- prevocational services;
- residential habilitation;
- supported employment-individual;
- supported employment-small group;
- AT not otherwise covered by Medicaid;
- clinical consultation - behavioral;
- clinical consultation - nursing;

- home or vehicle accessibility adaptations;
- specialized medical equipment/supplies not otherwise covered by Medicaid;
- supported living.

An individual may participate in the waiver by qualifying for as little as one (1) waiver service on a monthly basis (p. 35). Thus, an individual only taking advantage of respite [covered under the definition of “community living support” (p. 45)] may participate in the waiver. Conversely, there is no upper cap on the number of waiver services an individual can receive (p. 91).

2. The proposed age limitation is manifestly imprudent. There is no maximum age limit regardless of whether the waiver has ever had enrollees of extreme age (e.g. 100+). However, DMMA is proposing a minimum age of fourteen (14) (p. 22). This is an extension of an initiative begun in 2014. Until July 1, 2014, the waiver covered children ages 4 and up. In 2014, DMMA raised the limit from 4 to 12. The Councils objected to the change. Many of the considerations raised in 2014 remain apt:

A. Historically, DDDS has offered shared living/foster care for children with families with special interest and expertise in caring for individuals with developmental disabilities. If approved, DDDS could no longer pay for this service on behalf of children under age 14 with the federally subsidized waiver funds.

B. The attached DDDS enabling statute [Title 29 Del.C. §7909A] imposes a “duty” to provide “foster care placements”, “neighborhood homes”, and “supported living” without any exclusions based on age. In the absence of a statutory authorization to discriminate based on age, DDDS cannot limit its services to certain age groups without violating the Age Discrimination Act and its implementing regulations. When the Division adopted a policy of excluding minors from its group home system in the past, it was “prompted” to settle an HHS OCR complaint by rescinding the policy. See attachments. Cf. attached OCR directive to Division of Public Health that presumptive age limit for nursing home admission violates Age Discrimination Act and attached DSAAPD letter to DFS successfully challenging age limit on foster parents based on Age Discrimination Act. If CMS approves the age restriction in the waiver, DDDS will still have to provide residential and other waiver services to children under age 14. It will simply have to do so with no federal Medicaid match.

C. The DDDS enabling statute [§7909(c)(4)] requires DDDS to provide early intervention services to children ages 0-3. Early intervention services under the DHSS implementation of IDEA-Part C include a lengthy list of supports and services. See, e.g. Title 16 Del.C. §212. Moreover, some children with developmental disabilities are eligible for IDEA-Part B at birth. The Interagency Collaborative Team (ICT) [Title 14 Del.C. §3124] could prompt DDDS to provide residential programming to such children. If the children are ineligible for the waiver based on age, DDDS will have to provide residential services solely with state funds.

D. In the past, DDDS investigated systemic neglect of young children with developmental disabilities in a nursing facility (Harbor Health). See attached News Journal articles. The availability of waiver-funded residential options on an emergency basis would be an important resource if such a situation recurred. If the Division "ties its hands" by excluding pre-teens from the waiver, it loses capacity to address this type of situation.

E. The attached MOU between DDDS and the DSCY&F contemplates DDDS enrollment of children in the DDDS waiver in multiple contexts. The following is an example:

2. Residential placement of DFS children in DDDS homes and Respite Care:

When DFS is involved with a family because of child abuse, neglect, and/or dependency and the child has MR/DD and is placed in a DDDS foster home, the following activities will occur:...

b. The DDDS worker will do the following:

- Complete all DDDS residential paperwork and a Medicaid waiver packet in coordination with the DFS worker

The MOU envisions provision of several services covered by the DDDS waiver, including "specialized equipment" (p. 5); respite (pp. 5-6); shared living/foster care (p. 4); and case management (pp. 3 and 5-6). Indeed, the attached cover email announcing the MOU highlights the following as 1 of the 4 principal purposes: "2. Residential placement of DFS children in DDDS homes and respite care". From a fiscal perspective, it is simply imprudent for DDDS to categorically ban waiver eligibility of children under age 14, limiting the availability of Medicaid matching funds to meet children's needs. Conversely, it is difficult to imagine any "harm" in at least retaining the existing age 12 standard.¹

3. There may be some individuals who would qualify for both the DSHP+ and the Lifespan Waiver. Recognizing that an individual can only enroll in one waiver, it would be preferable when presenting institutional versus waiver options to include information about both the Lifespan waiver and DSHP+. The protocol on p. 43 could be amended to expand the scope of information provided to allow informed choice.

4. The section (p. 118) covering surrogate decision-making merits revision. This section characterizes guardians and agents operating under a power of attorney (POA) or supported decision-making (SDM) agreement as surrogates. Despite the varying roles of guardians and agents acting under a POA or SDM, the section incorrectly treats the surrogates as having equal authority and roles. The following are examples.

¹Paraphrasing, it is anomalous to name the revised waiver a "lifespan" waiver when DMMA has cut ten years off eligibility in two years. By analogy to the Diamond State Health Plan "Plus" designation, perhaps the DDDS waiver should logically be named the Lifespan "Minus" waiver.

A. The following sentences are not accurate if the surrogate is a guardian or an agent acting under a durable power of attorney on behalf of a participant who has become incompetent:

If the participant objects to a decision made by a surrogate, the participant's decision prevails. The participant may revoke the designation at any time.

B. The role of an agent under a supported decision making agreement is inconsistent with the following:

An Agency With Choice (AWC) broker must recognize the participant's surrogate as a decision-maker,...

Unless otherwise limited by the participant, the surrogate would have direction over the individual support plan for the Community Living Support service that is being self-directed, selection of caregiver, approval of the worker's timesheets with assurance each timesheet is accurate and truthful and negotiation of payment rates for the caregiver.

An agent acting under a supported decision-making agreement is not a "decision-maker", only a facilitator of the principal's deliberations. Concomitantly, the agent could never under the SDM enabling statute make decisions about the support plan, selection of caregivers, approval of timesheets, etc.

5. Individuals with TBI are included in the definition of "individuals with intellectual disabilities" and covered by the waiver (pp. 5 and 22). However, the instrument(s) used to determine level of care and to assess needs for the plan of care may be insufficient to validly assess level of care and needs. The same instrument is used to assess level of care for the waiver and institutional care (pp. 35-36). Use of a single instrument is contemplated for determining level of care (p. 39) and use of a single tool is contemplated for determining eligibility for residential services (pp. 57-58). A few tools are identified in developing the plan of care (p. 96). As DMMA is aware, it conducted a successful 2015-16 pilot of use of a supplemental assessment tool (Mayo-Portland Adaptability Inventory-4) and targeted brain injury questions in connection with the DSHP+. See attachments. The consensus was that the tool was useful for both the level of care determination and the determination of service needs. The waiver should include some explicit references to use of this supplemental assessment at p. 96 and elsewhere.

6. Eligibility of individuals with Prader-Willi Syndrome is unclear. Prader-Willi Syndrome is listed as an independent classification from intellectual disabilities and autism (pp. 5 and 22). The waiver category check-off then recites that it is limited to individuals with intellectual disability or autism (p. 22). The eligibility of individuals with Prader-Willi Syndrome should be clarified.

7. Financial eligibility is capped at 250% of the Federal Benefit Rate (FBR) (p. 29). CMS allows a higher cap, i.e., 300% of the FBR (p. 29). Given State public policy of encouraging gainful employment of persons with disabilities (19 Del.C. §§ 740-747; 16 Del.C. §5503), a higher cap would be appropriate. I recognize that the effect of the lower cap is mitigated by the post-eligibility disregard of all income of non-residential participants and all earned income of residential participants (p. 32). However, it is anomalous to have a higher income allowance post-eligibility than the allowance for initial eligibility. Adoption of a higher allowance for initial eligibility might allow some of the DDS clients working in the Bank of America program to qualify under the waiver.

8. Married couples have a right to live together in licensed long-term care facilities. See 16 Del.C. §1121(13). This concept is omitted from the “one-person shared living” standards reflected on p. 58.

9. The payment unit for “respite camp” is per “visit” (pp. 188, 190, and 194). This is cryptic. What is a “visit”?

10. The case management standards (pp. 92-93) are problematic. The Councils addressed concerns in their comments on 20 DE Reg. 247 (October 1, 2016). See attachment. In addition to concerns shared in the October communication, the waiver only requires a Community Navigator to have a face-to-face contact with a client once annually (p. 100). This contrasts with 4/year face-to-face contact for a Support Coordinator with a client (p. 101). The 1/year face-to-face contact for Community Navigators is a rather anemic standard which should be reconsidered. Finally, the unit of service for case management is omitted from Appendix J (p. 188). The rationale for the omission is not clear.

11. The waiver document sometimes refers to plans of care being revised annually and sometimes refers to plans of care being revised at least annually. Compare pp. 55 and 96 (only annual review) with pp. 98 and 100 (reviews triggered by changes in “medical status, behavioral status or circumstances” and at least annually. The references to only annual reviews should be modified.

12. A relative of a participant can be hired by a provider agency to supply supported living services (pp. 77-78). However, a provider cannot hire a qualified relative to supply supported employment-individual (pp. 61-62). It is difficult to identify a justification for allowing a relative to be hired by a provider to supply residential but not day supports. See also pp. 45 and 84 (qualified relatives can provide shared living services and community living support).

13. Page 56 would benefit from the addition of references to 19 Del.C. Ch. 10 and the federal Workforce Investment & Opportunity Act (WIOA) which regulate payment of subminimum wages.

14. The assistive technology standards (p. 66) merit revision.

A. The following categorical limit should be stricken: "Members must exhaust off the shelf products before DDDS will approve the purchase of any specialized medical equipment." DMMA cannot categorically require a failed attempt to use off-the-shelf products prior to a participant qualifying for specialized medical equipment. For example, if the prescribing therapist indicates that the "off the shelf" product is inadequate, that should be presumptively sufficient. Moreover, the categorical requirement of exhausting off-the-shelf AT ignores the multiple standards in the medical necessity regulation, including the following:

- be the most appropriate care or service that can be safely and effectively provided to the beneficiary;
- be sufficient in amount, scope and duration to reasonably achieve its purpose;
- Be recognized as either the treatment of choice (i.e. prevailing community or statewide standard) or common medical practice by the practitioner's peer group,...
- effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in a...Medicaid program..

B. The following categorical limit should be stricken: "Members are limited to the lowest cost option that will meet the person's needs, including refurbished equipment." The medical necessity regulation contains comprehensive standards. It is inaccurate to reproduce "snippets" of the full regulation which omits key considerations, including timeliness of acquisition, treatment of choice, improvement of physical or mental functionality, etc.. Moreover, the standard ostensibly requires purchase of refurbished equipment regardless of whether a new product would carry a warranty and have a longer predicted useful life.

15. Self-advocacy training is offered in residential programs (p. 57). It would be preferable to also offer self-advocacy training to non-residential waiver participants (pp. 45, 50 and 55). Parenthetically, it's unclear why different language is adopted for residential clients (self-advocacy training) vs. some non-residential clients (education in self determination - p. 50). Self-advocacy training would be particularly apt for participants electing to self-direct services.

16. Vehicle modification is available only if a vehicle is "the waiver participant's primary means of transportation" (p. 74). This is unduly constrictive. For example, a waiver participant may opt to use paratransit 51% of the time since it's inexpensive or provider-based transportation to work sites since it's free (pp. 61 and 63). Alternatively, a participant may have successfully completed driver-education training (using hand controls or adaptations) and obtained a driver's license. However, the participant is in a "Catch-22" if he wants to retrofit a vehicle - the participant can't meet the "primary means of transportation" standard since he can't get his vehicle adapted. Moreover, there are no comparable limits in similar contexts. For example, an individual does not have to prove that a wheelchair, AAC device, job coach, etc. will be used 51% of the time to qualify for the support.

17. The waiver allows exceptions to caps in several contexts, including respite (p. 46), supported living (p. 78), and assistive technology (p. 66). However, the cap on home and vehicle modifications is absolute with no discretion to make an exception (p. 74). This is short-sighted, especially since the cap applies to a lengthy (5 year) time period. Many factors can affect a participant's life over a 5-year period. If an exception is authorized, DMMA/DDDS could still rely on a general cap while still preserving some discretion to vary from the cap based on "exceptional need" (p. 66).

18. The standard (p. 74) for a contractor completing a home modification is as follows:

Must be licensed as a contractor to do business within the State of Delaware and hold all applicable certifications and standards, if required by trade, and general liability insurance.

This merits embellishment. For example, contractors working in New Castle County are required to have not only a State of Delaware business license but also a New Castle County contractor license. See attachment. It would also be preferable to include a requirement that the contractor provide a warranty if required by DHSS and a requirement that the contractor perform all work not only in conformity with the applicable building code (p. 73) but also any applicable permits. The requirement of a warranty will greatly enhance the ability of DHSS to prompt corrective action by a contractor. Otherwise, query how DHSS will effectively "correct" malfeasance after a contractor has been paid?

19. The waiver describes a "DDDS Authorized Provider Committee" which approves and disapproves providers of waiver services (p. 160). It is unclear which providers are subject to this approval process which is not mentioned elsewhere. For example, the home/vehicle modification contractor section (pp. 73-74) does not mention that contractors would be subject to this process.

20. The provider of "specialized medical equipment and supplies not otherwise covered by Medicaid" is exclusively limited to a durable medical equipment supplier enrolled pursuant to the State Plan (p. 77). This is short-sighted. It may be much cheaper to allow acquisition of supplies and equipment from Amazon or other retailers. Expensive items such as power lift chairs are less than half the price at Boscov's than through medical equipment suppliers. Moreover, the scope of the devices and controls covered by the definition of specialized medical equipment (p. 76) may extend to contexts in which a DME provider would not carry the equipment (e.g. hand controls for a vehicle). In the overlapping context of AT, DMMA has recognized that many items are available "off the shelf" (p. 66) and has adopted a more enlightened provider standard:

Entities qualified to supply AT equipment may include non-traditional off the shelf suppliers of equipment and technology as prescribed by a competent professional working within the scope of his or her practice.

At 68. At a minimum, DMMA should consider a similar authorization for specialized medical equipment and supplies.

21. There are several contexts in which relatives are authorized to provide services [e.g., supported living (pp. 77-78); shared living (p. 84); and community living support (pp 45-46)]. However, guardians are excluded. Id. The CMS waiver template ostensibly allows DMMA to allow guardians to be providers. Id. Under Delaware law, guardians are not expected to pay for supports from their own resources, only the resources of the ward. See attached Attorney General's opinion and 12 Del.C. §§3922(d) and 3923(f). This reduces the prospect for a financial conflict of interest. As a compromise, DMMA could consider retaining a general bar on guardians serving as providers in the above contexts subject to exceptions based on "exceptional need" or circumstances (p. 66).

22. DDDS currently funds many individuals in AdvoServ. Some residential AdvoServ clients are subject to the IBSER regulations and some are subject to the neighborhood home regulations. Compare 16 DE Admin Code §§3310 and 3320. The waiver only mentions neighborhood homes and omits any reference to IBSER residences (p. 82). The waiver recites that each resident "must have their own bedroom unless they express a preference to share a room" and residences are generally capped at 4 residents per home. In contrast, in the IBSER settings residents are crowded into small rooms with bunk beds (16 DE Admin Code 3320.6.6.6) and can have 10 residents per unit (16 DE Admin Code 3320.6.2.1). There are also DDDS non-residential clients at AdvoServ who would be subject to the IBSER regulations. The waiver does not indicate whether AdvoServ meets CMS standards for community-based settings (p. 12). If DHSS intends the waiver to cover clients served by AdvoServ, solely mentioning neighborhood group homes may be "underinclusive".

23. The waiver contemplates different plans for residential versus non-residential participants - a "Life Span Plan (LSP)" for clients in provider-managed residential settings and a "Support Plan for Individuals and Families (SPIF)" for clients living in a family home (p. 94). It would be preferable to have a single template/form for all waiver participants. This would have the following advantages: 1) easier transition between residential and non-residential services; 2) less confusion among families and professionals given multiple person centered plans; 3) less training since DDDS and provider staff only have to be trained on a single form; and 4) facilitation of data collection if the plans are compiled electronically with a search function. For example, if 40-50 individuals move between non-residential and residential services annually, wouldn't it be easier to modify a single plan than developing a new plan with a different template?

24. The section on DDDS internal appeals and Medicaid fair hearings should be revised. It recites in multiple sections (pp. 129-130) that appeals are available to contest reductions, suspensions or terminations of waiver services. They should also recite that a fair hearing is available to contest the "denial" of services. See 16 DE Admin Code §2101.2.0. It may also be appropriate to include a recital that participants can appeal a rights complaint decision. See p. 131 and 16 DE Admin Code §2101.2.0.

25. The exclusive reference to Mandt-compatible restraint (p. 136) may not apply to AdvoServ if it has been approved to use the Safety-Care restraint system. Parenthetically, there is some "tension" between the recital (p. 136) that restraints are limited to Mandt techniques and the recital (p. 139) that staff can be trained on a "DDDS-approved equivalent" to Mandt.

26. It would be appropriate to include a reference to restriction in the use of chemical restraint (pp. 135-136). See reference to chemical restraint on p. 137 and 16 Del.C. §1121(7). Moreover, at one time DMMA had a committee which reviewed the prescription of several psychotropic drugs to a Medicaid beneficiary as part of a quality-control process. The waiver mentions the Medical Care Advisory Committee (MCAC) involvement in quality control. It would be useful if there were a medical review of instances in which a waiver participant is prescribed a certain number of psychotropic drugs (e.g. 5 or more) to mitigate the potential for chemical restraint, tardive dyskinesia, etc.

27. The rate of payment for a personal attendant is 75% of the rate of a home health aide (p. 176). The rationale for the distinction is unclear. Indeed, attendants are authorized to perform a wider range of functions than home health aides. See 16 Del.C. Ch. 94, 24 Del.C. §1921(a)(14), and 16 Del.C. §12201b. The rate of payment for a personal attendant should be increased to at least the level of a home health aide.

28. Although not included in individual descriptions of these services, p. 175 recites that at least 2 bids/estimates are required for all specialized medical equipment not covered by the State Plan, all AT equipment, and all home/vehicle modifications. If this is a requirement, it should be disclosed prominently in the individual sections (e.g. pp. 66, 67-68, and 73-74). It would also be preferable to authorize exceptions at DDDS/DMMA discretion. For example, there may be situations in which acquisition must be quick to avoid health risk.

Attachments

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§ 7909A Division of Developmental Disabilities Services.

- (a) There is hereby established the Division of Developmental Disabilities Services under the direction and control of the Secretary of the Department of Health and Social Services.
- (b) The mission of the Division of Developmental Disabilities Services is to provide services and supports to individuals with developmental disabilities and their families which enable them to make informed choices that lead to an improved quality of life and meaningful participation in their communities.
- (c) The Division of Developmental Disabilities Services shall have the following powers and duties:
- (1) Provide community-based services including family supports, advocacy, foster care placements, respite, neighborhood homes, supported living, vocational and supported employment opportunities and day habilitation services;
 - (2) Provide case management, nursing, behavioral services, therapy and other professional supports needed to assist individuals in achieving their goal(s);
 - (3) Provide early intervention services to families so as to prevent or minimize developmental delays in children at risk who are ages 0-3; and
 - (4) Provide intermediate care facility residential services.
- (d) The Division of Developmental Disabilities Services shall ensure the investigation of complaints of abuse, neglect, mistreatment and financial exploitation. Such investigations may be in coordination with the Attorney General's Office, law enforcement or other appropriate agencies.
- (e) The Division of Developmental Disabilities Services shall be authorized to promulgate rules and regulations to implement this statute.

60 Del. Laws, c. 677, § 2; 73 Del. Laws, c. 97, § 6[5]; 78 Del. Laws, c. 179, § 315.;

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA

OFFICE OF THE SECRETARY
OFFICE FOR CIVIL RIGHTS
MAILING ADDRESS:
P.O. BOX 13716
PHILADELPHIA
PENNSYLVANIA 19101

Our Reference: . 03863006

DEC 6 3 1986

Mr. Brian J. Hartman
Disabilities Law Program
Community Legal Aid Society, Inc.
913 Washington Street
Wilmington, Delaware 19801

Dear Mr. Hartman:

On November 24, 1986, we received your request to withdraw your complaint against the Department of Health and Social Services (DHS). Specifically, your complaint related to group-home services for mentally retarded persons under age eighteen under the authority of the Age Discrimination Act of 1975 and its implementing Regulation, 45 CFR Part 91.

It is our understanding that the assurances outlined in the agency's November 12, 1986 letter to you, satisfactorily resolve the issues relating to the complaint. The agency has provided its policy of non-discrimination on the basis of age and its assurance that it does not exclude the participation of persons under age eighteen in its group-home services. In addition, the agency will provide you with periodic reports, within the next year, regarding its clients under age eighteen.

We have informed DHS that our office will require copies of all periodic reports sent to you. These submissions will be due to us at the same time as they are sent to you. We have also advised the agency that if the information indicates disparity in the age of the clients served, we may re-open your complaint for a formal investigation.

We do appreciate your efforts in resolving this complaint informally and we are hopeful that the agency will continue to be cooperative in adhering to their assurances. If you have any questions, please contact Ms. Barbara Banks, Director, Investigations Division, at (215) 596-6173.

Sincerely yours,

Paul F. Cushing
Paul F. Cushing
Regional Manager



STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MENTAL RETARDATION
802 SILVER LAKE BOULEVARD
ROBBINS BUILDING
DOVER, DELAWARE 19901

TELEPHONE: (302) 736-4386

OFFICE OF THE
DIRECTOR

November 12, 1986

Brian J. Hartman, Esquire
Community Legal Aid Society, Inc.
913 Washington Street
Wilmington, DE 19801

Re: Residential Services for Mentally Retarded Minors

Dear Brian:

This is to confirm that the Department of Health and Social Services, Division of Mental Retardation (DMR) does not now, nor has it, violated 45 C.F.R. Part 90 in DMR's provision of community-based residential services.

Enclosed is a copy of a memorandum circulated to the Intake Committee at DMR, dated September 19, 1986. This memorandum confirms our policy of nondiscrimination.

The DMR Intake Committee will actively consider [redacted] for placement in a group home setting consistent with his needs. DMR is not compelled by this letter, however, to determine that [redacted] is an appropriate candidate for admission to a group home.

[redacted] will continue to be actively considered as one of a group of priority candidates for a community placement commensurate with [redacted] s needs.

Within one month of the date of this letter, DMR will forward to you the following non-identifying information: the total number of non-adults presently in DMR ICF/MR and neighborhood group home settings, specifying dates of birth and identity of group home in which each such non-adult resides.

Finally, within six months and one year from the provision of the above data, DMR will forward to you the following non-identifying information:

a. the total number of non-adults applying for placement in DMR ICF/MR and neighborhood group homes within the preceding six months, specifying dates of birth and action taken on each application;

Brian J. Hartman, Esquire
November 12, 1986

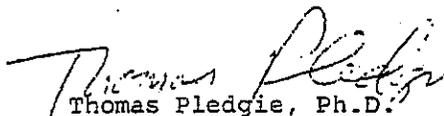
Page 2

b. the total number of non-adults in DMR ICF/MR and neighborhood group homes as of the respective dates, specifying dates of birth and identity of group home in which each such non-adult resides.

The terms of this letter are conditional upon your withdrawing the complaint in this matter.

Should there be material noncompliance with the representations in this letter, DMR understands that the complaint may be reopened until August 24, 1988, and that DMR waives its right to have such complaint heard in the first instance at the federal mediator level.

Very truly yours,



Thomas Pledge, Ph.D.

Director, Division of Mental Retardation

TP:twr

Enclosure

Susan Kirk-Ryan
Paul Cushing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION III
3636 MARKET STREET
PHILADELPHIA, PENNSYLVANIA

OCT 18 1985

Office of Health Facilities
OFFICE OF THE SECRETARY
OFFICE FOR CIVIL RIGHTS
MAILING ADDRESS:
P.O. BOX 13716
PHILADELPHIA
PENNSYLVANIA 19161

OCT 11 19

Mr. James E. Harvey
Director
Delaware Department of Health and
Social Services
Division of Public Health
Office of Health Facilities Licensing
and Certification
3000 Newport Gap Pike
Wilmington, Delaware 19808

Dear Mr. Harvey:

The Office for Civil Rights has completed its review of Delaware's Nursing Home Regulations for Skilled Care. Our analysis of the State's Regulations and determination regarding the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973 are as follows:

Section 57.3 - General Requirements

57.3 - An institution shall not admit any person under the age of fifteen (15) years of age as a patient unless approved by the State Board of Health.

Analysis

The Age Discrimination Act of 1975 and its implementing Regulation at 45 CFR Part 91, Subpart B Section 91.11(a) states that "No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance". Further, Section 91.11(b)(1) and (2) prohibits a recipient from using age distinctions which have the effect, on the basis of age, of excluding individuals from, or denying them the benefits of, or subjecting them to discrimination, under a program or activity receiving Federal financial assistance; denying or limiting individuals in their opportunity to participate in any Federally assisted program.

A recipient is permitted to take an action prohibited by Section 91.11 only if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity.

Determination

It is our preliminary determination that Section 57.3 of the State's Regulations violates the Age Discrimination Act of 1975 and 45 CFR, Part 91 Subpart B Section 91.11.

Unless the State Agency can show that its age distinction is necessary to the normal operation of a nursing home or the achievement of a statutory objective, the age distinction must be removed. Please refer to 45 CFR Sections 91.13, 91.14 and 91.15.

It is my understanding that the State Board of Health may, on a case-by-case basis, consider an application for admission to a nursing home from someone under the age of fifteen. However, if the applicant's age and not the medical condition is the reason for this case-by-case review, then it is probable that this action violates the Age Discrimination Act.

Remedy

If your age distinction does not meet the criteria set forth at 45 CFR Sections 91.13 and 91.14, you may voluntarily resolve this deficiency by deleting from your Nursing Home Regulations any reference to an age criterion. You may also notify the public as well as all skilled care nursing facilities of this change in policy.

Section 57.8 - Services to Patients

57.809 Mental Illness

A. Patients who are, or become, mentally ill and who may be harmful to themselves or others, shall not be admitted or retained in a nursing home.

Analysis

Section 504 of the Rehabilitation Act of 1973 and its implementing Regulation 45 CFR Part 84 prohibit discrimination on the basis of handicap in any program or activity receiving Federal financial assistance. Section 84.3 of 45 CFR defines a handicapped person as one who (1) has a physical or mental impairment which substantially limits one or more major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment.

Specifically 45 CFR Section 84.4 provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

The State Agency may not, solely by reason of the presence or history of handicapping condition (mental illness), deny admission to a nursing home. For purpose of admission to a nursing home, a facility must admit one who is a qualified handicapped person, i.e., meets the essential eligibility criteria and requires the same type of medical or related services that are normally provided. Thus, Section 504 prohibits recipients from categorically excluding persons with mental impairments, as is specified in the State's Regulations at 57.809.

However, a recipient may take into account the behavioral manifestations of the mental impairment in determining whether one is a qualified handicapped individual. If the manifestations are such that the person no longer meets the basic eligibility requirements for the receipt of services or cause substantial interference with the operation of the program (be harmful to self or others), the condition may be taken into consideration.

Conditions such as Alzheimers Disease may be considered a mental impairment under the definition of handicapping condition; however the presence of this condition and its manifestations may in no way render one ineligible for the receipt of services normally provided. However, if there is adherence to State Regulations, one with this disease may not be admitted nor retained in a nursing home, which could violate 45 CFR Part 84.

Determination

It is our preliminary determination, based upon the preceding discussion, that Section 57.809 as written violates Section 504 of the Rehabilitation Act and its implementing Regulation 45 CFR Section 84.4 and Section 84.52 (a)(1).

Remedy

In order to voluntarily resolve this deficiency, we suggest you delete "who are, or become mentally ill and" from the paragraph at 57.809A. Please disseminate the revisions to the public, referral sources and the State's skilled care facilities.

For your reference, we have enclosed a copy of each of the pertinent Regulations.

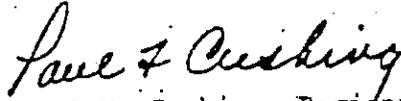
Page 4 - James E. Harvey

Please advise us of your plans to correct these deficiencies. We would appreciate a response by November 12, 1985.

If you need technical assistance or if you should have any comments or questions, please contact Ms. Barbara Banks, Director, Investigations Division, at (215) 596-6173.

We appreciate your continuous cooperation.

~~NAME FOR PURPOSE OF ASSISTANCE TO A DISTRICT OFFICE, A DISTRICT OFFICE~~
Sincerely yours,



Paul F. Cushing, Regional Manager
Office for Civil Rights
Region III

Enclosures

110

STATE OF DELAWARE
DEPARTMENT OF JUSTICE
STATE OFFICE BUILDING
820 N. FRENCH STREET, 8TH FLOOR
WILMINGTON, DELAWARE 19801

DIRECT DIAL: 571-25

CHARLES M. O'BRIEN III
ATTORNEY GENERAL

July 8, 1986

Mr. Paul F. Cushing
Regional Manager
Office for Civil Rights
Region III
P.O. Box 13716
Philadelphia, PA 19101

Re: Delaware's Nursing Home Regulations for Skilled Care

Dear Mr. Cushing:

Please be advised that effective June 1, 1986, Sections 57.809 and 57.3 of Delaware's Nursing Home Regulations for Skilled Care have been deleted. Notice of this deletion is being sent to all licensed providers. I have enclosed a copy of the May 2, 1986 minutes for your information.

As I have previously advised your office, it remains the position of the Delaware State Board of Health that there has been no discrimination based on age or mental illness and that these sections were promulgated to assist in the appropriate care and placement of clients. The Board has determined that these needs can be met through inspections by Health Facilities Licensing and Certification.

If you have any further questions, please contact me.

Very truly yours,

Patricia M. Furlong
Patricia M. Furlong
Deputy Attorney General

PMF/rd
Encl.

Xc: Hon. Thomas P. Eichler, Secretary
Lyman J. Olsen, M.D.
James E. Harvey



**DELAWARE HEALTH
AND SOCIAL SERVICES**

DIVISION OF SERVICES FOR AGING AND
ADULTS WITH PHYSICAL DISABILITIES

MEMORANDUM

DATE: January 8, 2014
TO: Ms. Elizabeth Timm
Division of Family Services
FROM: William Love, Director *W Love*
RE: 17 DE Reg. 608 (DFS Proposed Child Placing Agency Regulation)

The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) reviewed the proposed regulations regarding the *Delaware Requirements for Child Placing Agencies* as published as 17 DE Reg. 608 in the December 1, 2013, issue of the Register of Regulations. DSAAPD is concerned regarding:

- §95.1: *a licensee shall require that a foster parent applicant or approved foster parent is between twenty-one (21) years and sixty-five (65) years of age, and*
- §95.1.1: *a licensee may, at his or her own discretion, make exceptions to the above Regulation when the licensee documents that the health, safety and well-being of a child would not be endangered.*

I question the need and applicability of categorically barring anyone over 65 from becoming a foster parent simply due to his or her age. I also believe the age limit may be inconsistent with the Federal Age Discrimination Act. I recommend the regulations remove the age limit. Barring an applicant from becoming an approved foster parent should be based on an assessment which includes criteria specific to placement needs of the child and not based on an arbitrary age limit of 65.

Thank you for the opportunity to comment.

cc: Ms. Vicky Kelly, DSCYF
Mr. Brian Posey, AARP
Mr. Brian Hartman, Esq., CLASI
Ms. Daniese McMullin-Powell, DMMA
Ms. Pat Maichle, DDC
Ms. Jeanne Nutter, AARP



KNOW ABOUT THE FEDERAL LAW THAT PROTECTS AGAINST AGE DISCRIMINATION

What is the Age Discrimination Act?

The Age Discrimination Act of 1975 is a national law that prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance. The Age Discrimination Act applies to persons of all ages. Under the Age Act, recipients of federal financial assistance may not exclude, deny or limit services to, or otherwise discriminate against, persons on the basis of age.

The Age Act does not cover employment discrimination, which is enforced by the Equal Employment Opportunity Commission (EEOC).

The Office for Civil Rights (OCR), at the U.S. Department of Health and Human Services (HHS), ensures that entities that receive federal financial assistance comply with this law.

The Age Discrimination Act contains certain exceptions that allow, under limited circumstances, the use of age distinctions or factors other than age. For example, the Age Discrimination Act does not apply to an age distinction contained in a Federal, State or Local statute or ordinance adopted by an elected, general purpose legislative body that: provides any benefits or assistance to persons based on age; establishes criteria for participation in age-related terms; or describes intended beneficiaries or target groups in age-related terms.

Office for Civil Rights
U.S. Department of Health
and Human Services
200 Independence Avenue, SW
H.H.H. Building, Room 509 F
Washington, D.C. 20201

TELEPHONE
1-800-368-1019

E-MAIL
ocrmail@hhs.gov

TDD
1-800-537-7657

www.hhs.gov/ocr

How to file a complaint of discrimination with the Office for Civil Rights (OCR)

If you believe that you or someone else has been discriminated against because of age by an entity receiving financial assistance from HHS, you or your legal representative may file a complaint with OCR. Complaints must be filed within 180 days from the date of the alleged discrimination.

You may send a written complaint or you may complete and send OCR the Complaint Form available on our webpage at www.hhs.gov/ocr. The complaint form is also available on our webpage in a number of other languages under the Civil Rights Information in Other Languages section.

The following information must be included:

- Your name, address and telephone number.
- You must sign your name on everything you write. If you file a complaint on someone's behalf — e.g. spouse, friend, client, etc. — include your name, address, telephone number, and statement of your relationship to that person.
- Name and address of the institution or agency you believe discriminated.
- When, how and why you believe discrimination occurred.
- Any other relevant information.

If you mail the complaint, be sure to send it to the attention of the regional manager at the appropriate OCR regional office. OCR has ten regional offices and each regional office covers specific states. Complaints may also be mailed to OCR Headquarters at the following address:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW.
H.H.H. Building, Room 509-F
Washington, D.C. 20201

To learn more:

Visit us online at www.hhs.gov/ocr
Call us toll-free at 1-800-368-1019
Email us: ocrmail@hhs.gov
TDD: 1-800-537-7697

Language assistance services for OCR matters are available and provided free of charge. OCR services are accessible to persons with disabilities.

www.hhs.gov/ocr

AROUND DELAWARE

Harbor Healthcare settles U.S., Del. lawsuit

The United States and Delaware reached a \$150,000 settlement with Harbor Healthcare and Rehabilitation Center in Lewes related to allegations that care provided to children from 1998 through 1999 was inadequate. U.S. Attorney for Delaware Colm F. Connolly and Delaware Attorney General M. Jane Brady alleged Harbor submitted false claims to the government for payment since much of the care of a number of severely disabled children was inadequate. The government also alleged the center was understaffed and not properly trained. A lump sum of \$120,000 in the settlement will be paid to the government and a \$30,000 fund will be used to help Harbor's current patients. Harbor also is required to agree to have a neutral consultant monitor inspect the facility and report on its compliance. The monitor will cost Harbor as much as \$125,000.

11-1-05 NS

Long-term care gets overhaul

Guidelines geared to kids

By KIM DOUGLASS
Staff reporter

Delaware's new rules governing how chronically ill children should be cared for in nursing homes could be in place this year.

But the rules prompted by the deaths of several children in a Lewes-area nursing home in the late 1990s could be moot once they are reviewed and adopted.

Long-term care facilities in the state are designed primarily for adults, and state officials said they know of only about one or two children being cared for in a Delaware nursing home.

Most chronically ill Delaware children are being treated at home or out of state, and virtually all of them are covered under Medicaid, said Phil Soule, the state's Medicaid director.

Private insurance often will not cover such long-term care, and few families could afford the expenses, he said.

Yrene Waldron of the Delaware Health Care Facilities Association said that's unlikely to change, in part because caring for chronically ill children is very expensive.

"I know of no facility that's going to accept pediatric patients," she said. "The reimbursement for these types of clients is not commensurate with the cost of providing care."

Waldron said the new regulations make sense, but could make it even less likely that a nursing home would get into the business of long-term care for children.

In part, that's because the rules call for staff with specialties that are hard to find in Delaware, Waldron said.

But Sen. Robert Marshall, D-Wilmington West,

The rules call for such things as appropriately sized medical equipment and adequate, clean clothing for the children, who might suffer from severe injuries, birth defects or diseases.

an advocate for nursing-home reform, said the rules are important because some Delaware facilities could decide to go into the business of caring for children.

The rules call for such things as appropriately sized medical equipment and adequate, clean clothing for the children, who might suffer from severe injuries, birth defects or diseases.

The rules were drafted by the Division of Long-Term Care Residents Protection, and will be presented to the public for review during a hearing early this year.

Carey Slagle's son is among those being cared for in a home setting.

He was severely injured in a traffic accident about 10 years ago when he was 23 months old, and has been a resident of a Delaware nursing home for most of his life.

But that facility is trying to get out of the business of caring for children and urged Slagle to find a new setting for her son, she said.

The 30-year-old Middletown woman lives in a trailer and has two other

See RULES — B2

Rules: Long-term care for kids adjusted

FROM PAGE B1

children and could not care for her son at home, she said.

A Bear nurse agreed to take him into her home, and he has been in good hands there, Slagle said.

Slagle is glad for the new rules governing how children such as her son are cared for.

The nursing home took care of her son medically, she said. But "the kids would be in their rooms for hours at a time by themselves."

Her son sometimes was not bathed for days at a time, she said.

Eight Delawareans younger than 21 are being cared for in the

Voorhees Pediatric Facility in New Jersey, which is designed for children. It costs on average \$500,000 a year per child in Medicaid money Soule said.

That facility has a waiting list, he said.

Soule's office also pays for 190 sick Delaware children being cared for at home. Their expenses vary, but it generally costs less than it would if they were being treated at Voorhees, Soule said.

It would be hard for a Delaware facility comparable to the one at Voorhees to thrive because of the limited number of local children who need to be institutionalized, Soule said.

"You can't run a facility efficiently with 15 kids," he said. Delaware's new rules stem from investigations in the late 1990s after the deaths of six young patients at the Harbor Healthcare & Rehabilitation Center in Lewes between April 1998 and January 1999.

That facility was primarily in the business of caring for senior citizens, but operated a pediatric wing throughout the 1990s. It was cited by the state in recent years for the care it provided children, and started to get out of that business earlier this year.

► Reach Kim Douglass at 324-2895 or kdouglass@delawareonline.com.

Brian J. Hartman

From: Maichle Pat (DSHS) [pat.maichle@state.de.us]
Sent: Monday, July 09, 2007 1:18 PM
To: Hodges Kyle (DSHS); Wendy Strauss; Aileen.Fink@state.de.us; Barbara Monico; Bethel Chang; Brenda Kramer; bdonovan2003@aol.com; Brian J. Hartman; Carol.Barnett@state.de.us; Carol Reid Hall; Diann Jones; Harline Dennison; jlw Dover@aol.com; jknotts@dtcc.edu; Karen Gallagher; mahkila@comcast.net; lhenderson@independentresources.org; Laura Simmons; Linda.D.Barnett@state.de.us; eamcl@aol.com; Lora Lewis; lorrainel@logisticare.com; Marcy4boys@aol.com; Marie Anne Agahzadian; mark.devore@state.de.us; Mary.Anderson@state.de.us; Michael Gamel-McCormick; Phyllis Guinivan; rbeau97042@aol.com; Steve Tull; Sue Hansen; Theda Ellis; Vari Louann (K12); vince_19805@yahoo.com
Cc: Rose Al (DSHS); Lighter Sue (DSHS); Greene Deanna (DSHS)
Subject: FW: Memorandum of Understanding Between DSCYF and DHSS

This comes to us from the Child Mental Health.

Patricia L. Maichle
 Executive Director
 Developmental Disabilities Council
 Margaret M. O'Neill Building, 2nd Floor
 410 Federal St., Suite 2
 Dover, Delaware, 19901
 Phone: 302-739-2232
 Fax: 302-7392015
 E-mail: pat.maichle@state.de.us
 Web: www.ddc.delaware.gov

**"KNOWING IS NOT ENOUGH; WE MUST APPLY.
 WILLING IS NOT ENOUGH; WE MUST DO." GOETHE**

From: Cycyk Susan A (DSCYF)
Sent: Friday, July 06, 2007 3:04 PM
To: Maichle Pat (DSHS); 'Marcy4boys@aol.com'; 'jknotts@dcc.edu'; 'kramerSP88@aol.com'; 'lorrainel@logisticare.com'; 'eamcl@aol.com'; Lewis Lora (DHSS); Simmons Laura (OMB); 'jtapert@dtcc.edu'; 'srtull22@aol.com'; Vari Louann (K12); 'jlw Dover@aol.com'; 'maghaz@picofdel.org'; Greene Deanna (DSHS); Anderson Mary (DHSS); Barnett Carol (DHSS); Barnett Linda D (DHSS); Devore Mark (OMB); 'RBeau97042@aol.com'; 'vince_19805@yahoo.com'; 'bethelchang@comcast.net'; 'mahkila@comcast.net'; 'Denni5177@juno.com'; 'max@benedictineocp.org'; 'Theda.Ellis@delautism.org'; 'keghappyhour@aol.com'; 'mgm@udel.edu'; 'Pam5161@netzero.net'; 'bhartman@declasi.org'; 'lhenderson@independentresources.org'; 'dianncollins@gmail.com'; 'ncaquila@magpage.com'; A. Subramanian (asubramanian@riverside-dc.com); Aimee McFarlan (aimee.mcfarlan@uhsinc.com); Andrew Kind-Rubin; Barry Moore (bmoore@provcorp.com); Beth Krieger; Beverly Lawson (blawson@peoplesplace2.com); Beverly Ross; BKelsey@delawareguidance.org; Brad Berry; cannonj@diakon.org; Carolyn Graham; Cathy Rose; CChenkin@delawareguidance.org; Cha-Tanya Lankford; Chris Hampton (CHampton@delawareguidance.org); Cindy Knapp; Cynthia Coston; Dana Matheson; Casto David D (DSCYF); David Parcher; Amery Diane L. (DSCYF); Don Loden (Don.Loden@cffde.org); Donna J. Lentine Ph.D. (housewren@mchsi.com); Dory Zatuchni (jfs@jfsdelaware.org); Douglas Smith (Dousmith@christianacare.org); Eric Saul; Fern Spellman; Frances Stasko; Fritz Jones (fjones@ccwilm.org); Howard M. Isenberg (howard@holcombhhs.org); HSims@delawareguidance.org; James Larks (jlarks@net-centers.org); Jamie Hummell; John J. Friedman (jfreedo@comcast.net); John McKenna (John.McKenna@uhsinc.com); Joseph Hicks; jzingaro@comcast.net; Kumar Purohit (kumar.purohit@uhsinc.com); Ibegley@nbnrgroup.com; LCSW Elton G. Grunden (egrunden@ccwilm.org); Linda M. Leckel (lleckelsps@yahoo.com); Lisa Leidy-Williams; Mandel Much PH. D. (mmuch@comcast.net); Marc Felizzi; Maria Rayias; Marilyn Cockrell LCSW (mcockrell@ccwilm.org); Mark Casagrande (mcasagrande@jfsdelaware.org); Mary Dale; Michael Angstadt (mangstadt@twincedar.org); Michael Barbieri LCSW (mbarbieri28@comcast.net); Michael Kersteter (mkersteter@peoplesplace2.com); Nicholas Kotchision (nkotchision@ccwilm.org); NKeller@delawareguidance.org; Paul Wells (Pwells@mountainmanor.org); Rhonda Quin (rquin@delawareguidance.org); RMiller@DelawareGuidance.org; RN LCSW Joan Chatterton (JoanChat@aol.com);

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Subject: Memorandum of Understanding Between DSCYF and DHSS

I would like to take this opportunity to present to you the New **Memorandum of Understanding** between **The Department of Services for Children, Youth and Their Families** (The Division of Child Mental Health Services and The Division of Family Services) and **The Department of Health and Social Services** (The Division of Developmental Disabilities Services). The memorandum is attached for your review.

The purpose of this memorandum is to commit the three divisions (DCMHS, DFS and DDDS) to provide the appropriate services needed for children and youth with developmental disabilities and mental illness. The MOU better delineates responsibilities and maximizes cooperation between the Division regarding:

- 1. Joint planning and services for eligible children and families
- * 2. Residential placement of DFS children in DDDS homes and respite care
- 3. Developmental assessments of younger children in DDDS home and respite care
- 4. Transition of youth to adult services.

Through coordination amongst Three Divisions we can provide services of the highest quality and in the best interest of children and youth. That is the long term goal of this Memorandum of Understanding (MOU).

Towards operationalizing the MOU, our Deputy Directors have met with key leadership staff within each division. Divisional liaisons will meet quarterly to review system and procedural issues regarding the MOU and continue to improve our communication, coordination and service delivery for our children, youth and families.

DCMHS is pleased to be an integral collaborator in this MOU. Thanks to our management staff for their work in developing the MOU, and to all staff for their efforts to serve children and youth who are developmentally disabled and mentally ill. **Working together** across agencies will assure that every child and youth is served in the best possible way.

Regards,

Susan Cycyk

Susan A. Cycyk, M.Ed., CRC
Director, Div. of Child Mental Health Services
1825 Faulkland Rd., Wilm., DE 19805
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"Think of the Child First"

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**MEMORANDUM OF UNDERSTANDING
BETWEEN
THE DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES
THE DIVISION OF CHILD MENTAL HEALTH SERVICES
THE DIVISION OF FAMILY SERVICES**

AND

**THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
THE DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES**

I. PURPOSE

This cooperative agreement represents an understanding between the Department of Services for Children, Youth, and Their Families, The Division of Child Mental Health Services (DCMHS), The Division of Family Services (DFS), and the Department of Health and Social Services, the Division of Developmental Disabilities Services (DDDS), concerning children and their families served by DCMHS, DFS and DDDS where mental retardation/developmental disabilities (MR/DD), as defined by DDDS eligibility criteria, is suspected or is present. The purpose of this agreement is to delineate the responsibilities of the respective agencies in four areas:

1. Joint planning and services for eligible children and families
2. Residential placement of DFS children in DDDS homes and respite care
3. Developmental assessments of younger children ages 0-3
4. Transition of youth to adult services

This agreement is proposed and executed with the greatest spirit of cooperation and desire for ensuring the safety and welfare of children. All agencies recognize that certain action steps may be altered based on the specific needs of each child.

Memorandum of Understanding Among DCMHS~DFS~DDDS

II. AUTHORITY AND RESPONSIBILITIES

A. Authority

1. The Division of Child Mental Health Services

As required by Title 29 Del C. Ch. 90 § 9006, the Division of Child Mental Health Services shall be responsible for outpatient and residential mental health, preventive health services, and substance abuse treatment services for children and youth.

2. The Division of Family Services

As required by Title 29 Del C. Ch. 90 § 9006, Title 16 Del. C. Ch. 9 § 901, and Title 31 Del C § 302, shall take necessary action and provide comprehensive protective services for abused and neglected children. The child protection system seeks and promotes the safety of children who are the subject of child abuse and neglect reports.

3. Division of Developmental Disabilities Services – as required by Title 29 Del. C. Ch. 9 § 7909A.

The Division helps the people it serves achieve the quality of life they desire.

The DDDS acknowledges that persons with MR/DD share the same basic rights as all citizens. The DDDS shall facilitate the exercise and protection of such.

B. Responsibilities

1. **Joint planning and services:** When DFS is involved with a child or family because of child abuse, neglect, and/or dependency and any of the adult individual/caretakers have MR/DD, the following activities will occur:

- a. The DFS caseworker from the appropriate region (Attachment 1) will call the corresponding DDDS Community Services Regional Program Director (RPD). By the end of the working day, the RPD or designee will determine the status of the adult individual/caretaker relative to DDDS services. The information will be reported to DFS within 24 hours.
- b. If the adult individual/caretaker is an open case with DDDS, the DFS case worker and DDDS Family Support Specialist will develop a strategy to provide the most appropriate service to the family, including defining parameters of responsibility. The plan of intervention will include immediate action as well as any follow-up deemed mutually necessary. The DDDS Family Support Specialist shall assist DFS in developing a plan to reduce risk to children in the home while accommodating the support needs

Memorandum of Understanding Among DCMHS~DFS~DDDS

of the person with MR/DD. A joint service plan shall be developed and signed, outlining the responsibilities of each agency. DDDS and DFS shall convene on a quarterly basis (minimally) to discuss progress and ongoing problems within the family.

- c. If the adult individual/caretaker does not have an open case with DDDS but MR/DD is suspected, the DFS case worker will complete the MR/DD Screening Tool (Attachment 2). If the results of the screening tool indicate that the adult individual/caretaker may have MR/DD, then the procedure outlined in 1.b. (above) of this agreement will be initiated. DDDS will assist the family and DFS prior to the individual's eligibility for DDDS services is formally determined. Within the first 90 days, the adult individual/caretaker must formally apply for DDDS services and be found eligible. If the adult individual/caretaker needs assistance in completing the intake forms and obtaining the needed information, the DDDS worker will help the adult individual/caretaker complete the necessary forms.
- Both DDDS and DFS will cooperate to minimize separation of the adult individual/caretaker with MR/DD from their children, as long as the safety of the child can be ensured.
 - The Association for Rights of Citizens with Mental Retardation of Delaware (ARC) can be utilized by DFS/DDDS as a referral agent to help support the family.
 - The DDDS will expedite eligibility determination for adults and/or children whose cases fall under this MOU. DDDS services are voluntary and will be offered to the family as long as the family is willing to accept them.
- d. If the adult individual/caretaker is receiving services from DDDS and the DDDS Family Support Specialist becomes aware of the abuse or neglect of children, the DDDS Family Support Specialist will immediately report it to DFS by calling 1-800-292-9582 (Attachment 3). All social service personnel are mandated reporters and are required to report all known or suspected child abuse, neglect, or dependency.
- DFS uses the Risk Management Methodology to determine both the response time to begin the investigation and the determination of whether the children are at risk. DFS will complete the investigation within 45 calendar days and determine the need for ongoing services to the child and family.
 - DFS and DDDS will work together to develop the most appropriate support plan for the family as noted in 1.a. (above).

Memorandum of Understanding Among DCMHS~DFS~DDDS

- e. Children open with DFS and/or DCMHS and who may be eligible with DD DS, will be referred by the DFS or DCMHS case manager to DD DS. DD DS will review application and provide a status advisory within 4 business days of receipt of application. If child is subsequently determined eligible for DD DS services, a joint planning meeting will be convened to review service plan within 10 business days of said determination.
 - f. Children whose cases are open with DD DS and who may also be eligible for DCMHS services* (as defined by DCMHS eligibility criteria) will be referred to DCMHS intake. DCMHS intake process will take place and a response will be issued to the DD DS Family Support Specialist within 4 business days of receipt of complete referral information. If the child is eligible for DCMHS services, a joint planning meeting will be convened to review the service plan within 10 business days. If the child is ineligible for DCMHS services, DD DS can consult with DCMHS regarding appropriate and available services for their purchase.
 - g. Appeals of eligibility will be made pursuant to the DD DS and DCMHS Appeals procedure. A response will be made available within 5 business days. DFS, DCMHS, and DD DS will ensure that applicants are aware of the appeal processes and contacts for appropriate advocacy organizations.
 - h. Regional Managers from DD DS, DCMHS and DFS will meet on a quarterly basis to review specific policy and procedural and problematic cases and issues of mutual concern. Either party can request a meeting at an earlier time if it is case related.
2. **Residential placement of DFS children in DD DS homes and Respite Care:** When DFS is involved with a family because of child abuse, neglect, and/or dependency and the child has MR/DD and is placed in a DD DS foster home, the following activities will occur:

In order to receive residential services, the individual must be deemed as an "emergency" on the DD DS Registry and meet the definition for placement. *Emergency is defined as homeless with health and safety issues in the Emergency category of the DD DS Registry.*

- a. The DFS worker will do the following:
 - Complete the DD DS profile application and submit to DD DS intake, including all pertinent requested records.
 - Accompany the child to the placement and move their belongings.
 - Provide the DD DS worker and provider with information about the child.
 - Provide a copy of the custody order and Consent to Treatment Form.

Memorandum of Understanding Among DCMHS~DFS~DDDS

- Enroll the child in school, and attend IEP meetings.
- Develop the Plan for Child in Care within 30 days of placement. DDDS, the provider, and the child's family (if appropriate) shall participate in the planning.
- Provide services as needed to the child's family in an effort to reach permanency for the child
- Attend Child Placement Review Board (CPRB) meetings and Permanency Hearings
- Obtain an Educational Surrogate Parent if needed
- Enter the child in placement in FACTS (non-contractor provider, no pay)
- Handle all medical consents
- Facilitate applications for public benefits (e.g. Medicaid, SSI, Child Support, etc.)
- Help with special funding issues
- Make funeral arrangements with help from DDDS
- Work with DDDS case manager to address issues and concerns
- Two years in advance, work with DDDS case manager to determine the need for upcoming guardianship needs at age 18

b. The DDDS worker will do the following:

- Complete all DDDS residential paperwork and a Medicaid waiver packet in coordination with the DFS worker
- Meet the DFS worker and child at initial placement
- Visit the home every month
- Visit the school quarterly and attend IEP meetings
- Oversee, with a nurse consultant and provider, that child's medical appointments are kept:
 - a. Specialists as needed
 - b. Dental services
 - c. Immunizations up to date
 - d. Annual physicals
- Attend CPRB meetings and Permanency Hearings
- Complete an annual Essential Lifestyle Plan and forward copy to DFS
- Liaison with Medicaid for specialized equipment; contact DFS for funding as appropriate
- Keep DFS informed of concerns and changes in placement
- Complete all DDDS paperwork:
 - a. Annual home compliance check and contract signatures
 - b. Quarterly reports
 - c. Quarterly RN reports
 - d. Make respite arrangements

Memorandum of Understanding Among DCMHS~DFS~DDDS

- e. Work with the DFS worker to address issues and concerns
 - Two years in advance, work with DFS worker to determine the need for upcoming guardianship needs at age of 18

- c. Fiscal responsibility for Residential Placements
 - DDDS funding/payments must have prior approval from the DDDS Director of Community Services
 - DDDS will be representative payee for SSI and Social Security to the extent consistent with applicable law
 - DFS/DCMHS will facilitate the payment process if the DSCYF is the payee
 - DDDS will pay Difficulty of Care per new rate system. DFS will pay according to child Level of Care Rate. DCMHS pays according to medical necessity and clinical eligibility. Any costs that exceed the allowable agency rates must be jointly agreed upon. If additional funding is needed for the placement, it will be negotiated among DDDS, DFS, and DCMHS.
 - DDDS will designate contact person(s) for all issues related to payments. (Attachment 1)
 - At the beginning of the fiscal year, DDDS will submit an annual cost projection for each child residing in a DDDS foster home. This will be followed by an intergovernmental voucher that lists the name of the child and the annual projected cost of care attributed to DFS and DCMHS.
 - DMSS client payments will notify the DDDS Director of Client Benefits of all child support payments which are received on children who are served jointly. This notification must occur at least once each quarter.

- d. Respite
 - When respite occurs with DDDS providers:
 - A DDDS respite agreement will be signed before the respite takes place unless an emergency placement is authorized by a DDDS administrator.
 - Funding shall be shared in accordance with the established formula, which is reviewed annually. If DCMHS services are involved, continued utilization is monitored regularly to determine ongoing medical necessity.
 - DDDS Respite Coordinator shall submit a DFS FACTS Registration Form for each DDDS Respite Provider to the DFS Foster Care Manager to facilitate payment.
 - DFS makes respite payments directly to the provider.

Memorandum of Understanding Among DCMHS~DFS~DDDS

- When respite placement costs exceeds DDDS' rate system limit or requires placement other than foster families:
 - DFS, DCMHS, and DDDS representatives will jointly review the case, possible placements, and determine placement resources. They will also determine which agency will be the lead agency to follow up on the details of arranging the placement.
 - If DDDS does not have a provider, DFS has the option of approving an appropriate provider to provide respite, as they would with any other family active with DFS.
- 3. **Developmental assessments of young children ages 0-3:**

When a child ages 0-3 in the custody of DFS is suspected of or has developmental delays and the parents are not available to initiate Part C services, the DFS worker will make a referral to Child Development Watch (CDW).
- 4. **Transition of youth to adult services:**

When a youth in the custody of DFS and/or receiving services from CMH has been determined eligible to receive DDDS services and is listed in the DDDS *Registry*, the DFS caseworker or CMH caseworker (as appropriate) shall contact by email or letter the DDDS Community Services Regional Program Director (RPD) from the applicable region (Attachment 1) within 30 days following the youth's 16th birthday to initiate transition to adult services planning. When a youth in the custody of DFS and/or receiving services from CMH is suspected of having mental retardation/developmental disabilities (MR/DD), as defined by DDDS eligibility criteria, the DFS caseworker or CMH caseworker (as appropriate) will make a referral to the DDDS Office of Applicant Services within 30 days following the youth's 16th birthday to initiate the application process and transition to adult services planning. Both scenarios assume discharge from DFS or CMH at age 18.

III. DISPUTE RESOLUTION

If issues come up that cannot be resolved by the staff working directly with the child and their family, the respective supervisors should be alerted to attempt to resolve the issues. If resolution cannot be accomplished at the supervisory level, then Division liaisons should be contacted to assist in the resolution.

Memorandum of Understanding Among DCMHS~DFS~DDDS

IV. CONFIDENTIALITY

The Divisions of Child Mental Health Services, Family Services, and Developmental Disabilities Services agree to exchange client/family information on families and children served by either Division in instances where information exchange is in the best interest of families or children needing or requesting services for either Division. (29 Del. C. §9016)

It is understood that information exchanged by any Division shall be restricted to client/family record reports and documents clearly pertinent to the family's or child's needs or problems. Further, any information exchanged shall only be used to facilitate efficient and timely evaluation, the provision of services and/or resolution of patient/client needs. Each Division assures that the confidential character of exchanged information will be preserved and, under no circumstances will exchanged information be shared with any agency, program or person not party to this agreement without the express written consent of the family or by the authority of Family Court.

No information in any form can be exchanged about drug or alcohol abuse treatment or sexually transmitted disease information without specific written consent for this information. Information about HIV testing or HIV status can only be shared with specific consent or if the Division of Family Services holds legal custody of that child.

V. Administration of Memorandum

Each agency agrees to assign appropriate program staff to serve as the points of contact for the purposes of effective and efficient management of the children and families served under this MOU.

It is expected that these staff will meet on a quarterly basis to ensure that the intent and spirit of this MOU is fully implemented.

MOU Attachments include:

- Attachment 1 – Names and telephone numbers of the staff described in this Memorandum of Understanding (included in this document)
- Attachment 2 – DDDS Quick Screen Tool for Identifying Individuals with a Possible Developmental Disability
- Attachment 3 – Child Abuse/Neglect Mandatory Reporting Form
- Attachment 4 – DCMHS Eligibility Criteria
- Attachment 5 – DDDS Eligibility Criteria

Memorandum of Understanding Among DCMHS~DFS~DDDS

This agreement is proposed and executed with the greatest spirit of cooperation and desire for client-centered activities. All agencies recognize that certain action steps may be altered based on specific individual's needs.

This Memorandum of Understanding will be reviewed annually.

Cari DeSantis, Secretary
Department of Services for Children,
Youth, & Their Families

Vincent P. Meconi, Secretary Department
of Health and Social Services

Susan Cycyk, Director
Division of Child Mental Health Services

Carlyse Giddins, Director
Division of Family Services

Marianne Smith, Director
Division of Developmental Disabilities

1. Administration of the Memorandum/Staff Contacts

Each agency has identified a liaison to address interagency issues:

DCMHS: Harvey Doppelt, Ph.D.
Clinical Psychologist
Community Mental Health Regional Director
1825 Faulkland Road, Main Administration Building # 2
Wilmington, DE 19805
(302) 633-2739

DFS: John Bates
Foster Care Program Manager
1825 Faulkland Road, Main Administration Building # 2
Wilmington, DE 19805
(302) 633-2643

DMSS: Theresa Stafford
Sr. Accountant, Client Payments
Barley Mill Plaza, Building 18
4417 Lancaster Pike
Wilmington, DE 19805
(302) 892-4532

DDDS: Flossie Ford
Client Benefits Accountant, Fiscal Unit
Jesse Cooper Building
Federal and Water Street
Dover, DE 19901
(302) 744-9600

1. New Castle County

DFS

Elwyn Office
321 East 11th Street
Suite 300
Wilmington, DE 19802
Phone: (302) 577-3824
Fax: (302) 577-7793
Contact: Debbie Colligan
Assistant Regional
Administrator

DDDS

Early Intervention Program
2055 Limestone Road
Suite 215
Wilmington, DE 19808
Phone: (302) 995-8576
Fax: (302) 995-8363
Contact: EIP Director
Sr. Social Service Administrator

DCMHS

**Division Child Mental Health
Services (DCMHS)
Main Administration**
1825 Faulkland Road
Main Administration Building # 2
Wilmington, DE 19805
Phone: (302) 633-2739
Fax: (302) 633-2614
Contact: Harvey Doppelt, Ph.D.
Clinical Psychologist
Community Mental Health
Regional Director

1. Administration of the Memorandum/Staff Contacts1. New Castle CountyDFS

University Plaza
 Cambridge Building
 263 Chapman Road
 Newark, DE 19702
 Phone: (302) 451-2800
 Fax: (302) 451-2821
 Contact: Dave Desmond
 Assistant Regional
 Administrator

DDDS

University Plaza
 Stockton Building
 263 Chapman Road
 Newark, DE 19702
 Phone: (302) 369-2180
 Fax: (302) 368-6596
 Contact: Michael Paoli
 Regional Program Director

DCMHS

University Plaza
 Cambridge Building
 1825 Faulkland Road
 Main Administration Building # 2
 Wilmington, DE 19805
 Phone: (302) 633-2739
 Fax: (302) 633-2614
 Contact: Harvey Doppelt, Ph.D.
 Clinical Psychologist
 Community Mental Health
 Regional Director

2. Kent CountyDFS

Barratt Building
 821 Silver Lake Boulevard
 Suite 200
 Dover, DE 19904
 Phone: (302) 739-4800
 Fax: (302) 739-6236
 Contact: Diana Fraker
 Assistant Regional
 Administrator

DDDS

Thomas Collins Building
 540 S. DuPont Highway
 Suite 8
 Dover, DE 19901
 Phone: (302) 744-1110
 Fax: (302) 739-5535
 Contact: Albert Anderson
 Regional Program Director

DCMHS

Georgetown State Service Center
 546 S. Bedford St.
 Room 2110
 Georgetown, DE 19947
 Phone: (302) 856-5826
 Fax: (302) 856-5824
 Contact: David Lindemer, Ph.D.
 Child Psychologist Supervisor

3. Sussex CountyDFS

Georgetown
 546 South Bedford Street
 Georgetown, DE 19947
 Phone: (302) 856-5450
 Fax: (302) 856-5062
 Contact: Margaret Anderson
 Assistant Regional
 Administrator

DDDS

Georgetown
 Community Services
 26351 Patriots Way
 Georgetown, DE 19947
 Phone: (302) 933-3135
 Fax: (302) 934-6193
 Contact: Carey Hocker
 Regional Program Director

DCMHS

Georgetown State Service Center
 546 S. Bedford St.
 Room 2110
 Georgetown, DE 19947
 Phone: (302) 856-5826
 Fax: (302) 856-5824
 Contact: David Lindemer, Ph.D.
 Child Psychologist Supervisor

1. Administration of the Memorandum/Staff Contacts

3. Sussex County

DFS

DDDS

DCMHS

Pyle

Rte. 2, P.O. Box 281-1
Frankford, DE 19945
Phone: (302) 732-9510
Fax: (302) 732-5486
Contact: Margaret Anderson
Assistant Regional
Administrator

Seaford

350 Virginia Avenue
Seaford, DE 19973
Phone: (302) 628-2024
Fax: (302) 628-2041
Contact: Margaret Anderson
Assistant Regional
Administrator

Milford

11-13 Church Avenue
Milford, DE 19963
Phone: (302) 422-1400
Fax: (302) 424-2950
Contact: Susan Taylor-Walls
Assistant Regional
Administrator

4. To Report Child Abuse or Neglect:

Statewide Report

Line Number: 1 (800) 292-9582 (24 hours a day/7 days a week)

2. DDDS Quick Screen Tool

Identifying Individuals with a Possible Developmental Disability

Name: _____ Date: _____

Address: _____

Age: _____ Informant/s: _____

Screening completed by: _____

1. Is there documentation that the individual's deficits or limitations began prior to age 22 (for example: enrolled in special school or program, previous diagnosis of some type of mental retardation, autism, documentation of delays in development, or an IQ below 70)?

2. Does the individual have a high school diploma or a certificate of attendance? If neither, it is clear that the individual did not attend or regularly attend and complete school.

3. Is the individual performing substantially below the level expected for his/her age in two or more of the following adaptive skills areas (see definitions noted on the back of this form)? If so, circle those applicable.
 - a. Communication
 - b. Self-Care
 - c. Home Living
 - d. Social
 - e. Community Use
 - f. Self-Direction
 - g. Health and Safety
 - h. Functional Academics
 - i. Leisure
 - j. Work

4. Is it clear that the individual did not function at a higher or more independent level at a previous time in his/her life?

2. DDDS Quick Screen Tool

Adaptive Skills Areas

- a. Communication: Ability to understand and express information through symbolic behavior (spoken word, written word, sign language, manually coded English) or non-symbolic behaviors (e.g.: facial expressions, body, body movement, touch, gesture).
- b. Self-care: skills involved in toileting, eating, dressing, hygiene, and grooming.
- c. Home living: home-related skills such as cooking, clothing care, housekeeping, food preparation, planning/budgeting for shopping, and home safety.
- d. Social skills related to social interactions with others such as initiating, interacting, and terminating interactions, making choices, coping with demands, confirming conduct to social norms, and displaying appropriate socio-sexual-behavior.
- e. Community use: skills related to the appropriate use of community resources, travel in the community, shopping in stores, purchasing/obtaining services from community businesses, visiting places/events.
- f. Self-Direction: skills related to making choices, learning and following a schedule, engaging in/initiating activities of personal interest that are appropriate to the setting and conditions.
- g. Health and Safety skills: related to the maintenance of owns own health in terms of eating, identification of illness, treatment and prevention, basic first aid, sexuality, physical fitness, and interacting with strangers.
- h. Functional Academics: cognitive abilities and skills related to school that also have direct application in one's life (e.g.: writing, reading, basic science). Of importance is not the grade-level, but that the skills are functional in terms of independent living.
- i. Leisure: the development of a variety of leisure and recreational interests that reflect personal choice and preferences. Skills would be choosing and self-initiating interests, using home and community activities with others and/or alone and determining amount and type of involvement.
- j. Work: skills related to holding a part or full-time job in the community in terms of specific job skills and appropriate social behavior.

3. Child Abuse/Neglect Mandatory Reporting Form



State of Delaware
The Department of Services
for Children, Youth, and
Their Families

DIVISION OF FAMILY SERVICES
CHILD ABUSE/NEGLECT MANDATORY REPORTING FORM
 (Title 16, Delaware Code, Chapter 9, Subsections 901-914)
 Toll Free 24-Hour Report Line 1-800-292-8582

INSTRUCTIONS: Any physician, and any other medical person in the healing arts including any person licensed to render services in medicine, osteopathy, dentistry, any intern, resident, nurse, medical examiner, school employee, social worker, psychologist, or any other person who knows or reasonably suspects child abuse or neglect shall make an oral report to the Report Line using the number at the top of this page in accordance with 16 Del.C. §903.

Within 72 hours after the oral report, send a completed Child Abuse/Neglect Mandatory Reporting Form to the following address: Please type or print the information and sign the form on the back.

DIVISION OF FAMILY SERVICES – STATE OF DELAWARE
 87 Reads Way
 New Castle, DE 19720-1648

IDENTIFYING INFORMATION

Child's Name (Last, First, Initial)	Date of Birth/ Age	Sex	Race	Victim (Yes/No)
--	-----------------------	-----	------	--------------------

1. _____

Current Address: _____

2. _____

Current Address: _____

3. _____

Current Address: _____

4. _____

Current Address: _____

5. _____

Current Address: _____

Parents/Custodians/Caretakers' Names (Last, First, Initial)	Date of Birth/ Age	Sex	Race	Perpetrator (Yes/No)
--	-----------------------	-----	------	-------------------------

6. **Mother**

Current Address: _____

7. **Father**

Current Address: _____

8. **Custodian/Caretaker (Relationship)**

Current Address: _____

Please specify for numbers 1 - 8 above:

Foreign language spoken: #s _____ Specify type: _____

Disabilities: #s _____ Specify type: _____

3. Child Abuse/Neglect Mandatory Reporting Form

DESCRIPTION

1 Describe the child's current condition/injuries and the reason you suspect abuse/neglect. Include evidence, if known, of prior abuse and/or neglect to this child or sibling. Add pages or attach further written documentation as needed.

2. If applicable, note the exact location of any injury by placing a number on the model below. Use the lines to the right of the models to describe the corresponding injury that each number represents. Check the category of injuries below.
 ___ Physical Abuse ___ Sexual Abuse ___ Physical Neglect

The form includes several anatomical diagrams for injury location reporting:

- Two full-body silhouettes (front and back).
- Three head profiles (left profile, front view, right profile).
- Two hand diagrams (dorsal and palmar views).
- Two foot diagrams (dorsal and plantar views).

 To the right of these diagrams are ten horizontal lines for describing injuries.

3. Actions taken "T" or pending "P"
 ___ Medical Examination ___ Notification of Police
 ___ X-Rays ___ Notification of Medical Examiner
 ___ Photographs ___ Other: _____

REPORTING SOURCE (CONFIDENTIAL)

Signature	Title or Relationship to Child	Date of Report
Facility/Organization	Address	Telephone No.

REPORT LINE USE ONLY

Date of Oral Report: _____ Report was: ___ Accepted ___ Rejected

Date Written Report Received: _____

Prior DFS Case Activity/Reports? ___ Yes ___ No If "yes", specify dates: _____

4. DCMHS Eligibility Criteria

Division of Child Mental Health Services
Department of Services for Children Youth and Their Families
State of Delaware

CS 001 **DCMHS SERVICE ELIGIBILITY**

Authored by: **Utilization Management Committee**
Approved by: Susan Cycyk, M.Ed., C.R.C., C.P.R.C.
Date: November 29, 2006

Title: Division Director
Originated: 5/01/97 Revisions: 12/19/99; 11/19/03; 8/31/05; 11/29/06

PURPOSE: To define eligibility criteria for services provided by the Division of Child Mental Health Services ("DCMHS"), State of Delaware.

DEFINITIONS: Applicable definitions are given in the appendix to DCMHS policy "Development and Revision of Policies."

POLICY: Consistent with statutory authority (16 Del C. chapter 90), agreement with the State Medicaid Office under the Diamond State Health Plan (DSHP), the HCFA 1115 waiver, DCMHS hereby establishes eligibility criteria for mental health and substance abuse services for children and youth who are served by DCMHS. Eligibility for service is established when criteria 1, 2, 3, and 4 below are all met or when criteria 5 is met.

1. Age: Children and youth are eligible:

A. Up to Age 18 -Children and youth are eligible for services until their 18th birthday.

B. Over age 18 -For those youth active with DFS or DYRS and over the age of 18, DCMHS may:

- 1) Manage the case and provide services available through DSCYF consolidated contracts, and/or
- 2) Provide its Consultation and Assessment service for diagnostic services and treatment planning up to age 19.

2. Residence: Delaware residents are eligible for services.

3. Medical Necessity: Medical necessity is established by the application of DCMHS "Level of Care Criteria." These criteria are available on the DCMHS website.

4. Categorical Eligibility:

A. Insurance and Medicaid Benefits: DCMHS services are intended as a primary resource for those who have no other reasonable means to pay for mental health services i.e. individuals who have:

- 1) Medicaid benefits, and require extended services beyond the 30 unit Diamond State Health Plan outpatient benefit or require a higher level of service than is provided by DSHP outpatient benefits, or
- 2) No Medicaid and no private mental health or substance abuse benefits, or
- 3) Exhausted all applicable private insurance mental health or substance abuse benefits.
Please note that the absence of a level of care or specific provider in a mental health insurance package is not grounds for categorical eligibility.

B Insurance Co-pay: In general, DCMHS does not function as a secondary payor for the purpose of funding insurance co-payment for the privately insured. There are two exceptions:

- 1) If a youth is hospitalized in a DCMHS designated psychiatric hospital on an involuntary basis, or is hospitalized on an emergency basis with DCMHS authorization, and the hospital is unsuccessful in obtaining reimbursement for the private insurance, then DCMHS may reimburse the Provider up to the allowable Contract rate for up to 72 hours.
- 2) If a youth has both private insurance and Medicaid, where the private insurer is the primary payor and Medicaid is the secondary payor, then the parent, legal guardian or other legally liable individual

4. DCMHS Eligibility Criteria

is not responsible for any co-pay amount and by federal regulation private providers may not bill parents for that amount. In such a situation, Medicaid providers who have a contract with DCMHS may be reimbursed up to the Medicaid rate in cases pre-authorized by DCMHS. If the provider and Medicaid recipient wish to utilize any applicable Medicaid coverage to pay costs after the primary insurance has paid allowable charges, the provider must obtain DCMHS authorization for the service prior to the initiation of the service, in addition to any other authorizations which may be required by other payers.

C. Duplicated DSCYF Services: DCMHS provides mental health and substance abuse treatment for children and youth active with another division when the mental health or substance abuse treatment is not available through the other division, or as otherwise specified in an MOU with another DSCYF division.

D. For clients meeting eligibility requirements for DCMHS services, and who also qualify for services from other state agencies, divisions within state agencies, school districts, physical/medical health care services, and/or other services, DCMHS will provide medically necessary mental health and substance abuse services arranged in concert with these other agencies. DCMHS does not provide services that substitute for services which are the responsibility of another agency.

5. Mental Health Crises – Crisis services may be provided to children and youth meeting criteria A. or B. below.

A. DCMHS crisis services and short-term emergency hospitalizations may be provided to non-resident youth under the age of 18 years of age who are in the State of Delaware and are at imminent danger to self or others arising from mental health or substance abuse disorders. DCMHS reserves the right to seek reimbursement for services provided to non-Delaware residents.

B. The DCMHS crisis service also may be utilized by privately insured persons if they meet criteria 1, 2, and 3 above for initial crisis response (excluding crisis bed) intervention, but subsequent treatment is the responsibility of the insurance carrier unless the youth otherwise meets eligibility criteria and is admitted to DCMHS services.

APPLICATION:

A. The application of this policy in a particular circumstance may be appealed by the affected parent or guardian, custodian or other legal caregiver if the parent is unavailable. (See also DCMHS Appeals Policy).

- 1) Providers and advocates may assist children and families with an appeal under this policy.
- 2) Families will be advised of their appeal rights whenever a client is determined to be ineligible for DCMHS services under this policy.
- 3) When DFS or DYRS has legal custody, staff in disagreement with DCMHS decisions should use the DSCYF case dispute resolution procedures instead of the appeal procedures.

B. DCMHS staff may request a review by the Division Director if application of the policy would yield a result substantially contrary to the combined interests of the State and the client. The decision of the Director will be documented in writing and signed by the Director, and kept on file by the DCMHS Quality Improvement unit.

Mydocs/UR/CS001Rev11-29-06.doc

4. DCMHS Eligibility Criteria

*DELAWARE DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
ELIGIBILITY CRITERIA*

The Division of Developmental Disabilities Services provides services to those individuals whose disability meets all of the following conditions:

- (A) (i) is attributable to mental retardation (1992 AAMR definition) and/or (ii) Autism (DSM IV) and/or (iii) Prader Willi (documented medical diagnosis) and/or (iv) brain injury (individual meets all criteria of the 1992 AAMR definition including age manifestation) and/or (v) is attributable to a neurological condition closely related to mental retardation because such condition results in an impairment of general intellectual functioning and adaptive behavior similar to persons with mental retardation and requires treatment and services similar to those required for persons with impairments of general intellectual functioning;
- (B) is manifested before age 22
- (C) is expected to continue indefinitely;
- (D) results in substantial functional limitations in 2 or more of the following adaptive skill areas
 - 1) communication;
 - 2) self-care;
 - 3) home living;
 - 4) social skills;
 - 5) community use;
 - 6) self-direction;
 - 7) health and safety;
 - 8) functional academics;
 - 9) leisure;
 - 10) work; and
- (E) reflects the need for lifelong and individually planned services.

Intellectual functioning and adaptive behavior is determined by using established standardized tests approved by the Division.

Effective 7-10-2000

EXCERPT

**STATE COUNCIL FOR PERSONS WITH DISABILITIES'
BRAIN INJURY COMMITTEE
August 1, 2016 – 2:00 PM
Smyrna Rest Area Conference Room, Smyrna**

PRESENT: Ann Phillips, Chair/Family Voices; Brian Hartman, Vice-Chair/Disabilities Law Program; Linda Brittingham, Christiana Care Health System; Tammy Clifton, DVR/BIAD; Dr. Jane Crowley, A.I. duPont Hospital for Children; Debbie Dunlap, Parent; Dr. Katie Freeman, DPBHS; Carrie Hocker, DDDS; Sharon Lyons, BIAD; Lenore Reynolds, UHCC; Ron Sarg, DMD, DE Commission of Veterans Affairs (DCVA); Tiffany Stewart, Point of Hope; Jamila Waigwa, DSAAPD; Kyle Hodges, Staff; and Amber Rivard, Support Staff.

Guests: Kim Pettyjohn, RN – DMMA
Marcella England – DMMA
Anne Dunlap

CALL TO ORDER

The meeting was called to order at 2:15 pm.

ADDITIONS TO THE AGENDA

Announcements - Kyle

APPROVAL OF MINUTES

Brian made a motion to approve the minutes. Ron seconded the motion. The May 2, 2016 minutes were approved as submitted.

BUSINESS



DMMA Presentation on TBI Assessment Pilot & Data Collection

Kim spoke about preliminary data on the TBI Assessment Pilot (handout), which included a breakdown of the first three months (11/1/15-1/31/16) and the last three months 2/1/16-4/30/16) of the pilot. She distributed the same information in a color document (handout). She spoke about the data collected in the last three months because the previous data had previously been discussed. There was a total of 333 community referrals compared to 279 referrals in the previous three months. There were a total of 257 applicants screened, with 250 that were approved and 7 denied. There were 39 approved and 3 were denied using the PAE and TBI Form. There were 37 applicants identified with a TBI after asking the trigger questions, which would not have been previously identified. There were 11 people that were already known to have a diagnosis of a TBI. There were 34 applicants who withdrew, expired or changed their request.

Kim stated that using the trigger questions brought to light that people were being missed as having a TBI in the previous assessments. Next steps include meeting with the MCOs (Managed Care Organizations) and DMMA's Managed Care Operations in the next couple of weeks to discuss incorporating the information gathered and what tools they will utilize. Kim stated that she

reviewed United Health Care's and Highmark's assessment tools, and most of the questions that Highmark uses are the same questions that are on the MPAI4 tool.

Kim spoke briefly about the new CMS Managed Care Rule that is forthcoming. This Rule will have significant changes and there will be one assessment tool that all MCOs will be required to use. The effective date for this is unknown. Kim could not answer the question about those identified with TBI getting extra services since that is done by the MCOs. Ann stated that the CMS Rule has specific dates for implementation of each category. Kim added that Glyne would have more specific information regarding this. Kim explained that Pre-Admission Screening would still continue the pilot, including asking the trigger questions until a decision is made on how the MCOs will incorporate it into their process. Ann expressed concern as to what will happen to those who were in the system before the pilot. Kim said that the trigger questions did not affect eligibility.

Debbie asked if CMS would be developing the new evaluation. Kim explained that CMS would most likely state what needs to be included in the assessment tool rather than having an assessment tool. Each state has the flexibility to do more. A question was asked if Highmark was using their form for any type of brain injury or just TBI. Kim explained that once everyone is financially and medically approved, the MCOs do an initial comprehensive assessment using their assessment tool, and care planning and eligibility for services is based upon this assessment. Marcella added that the questions would be included. Kyle asked how many were identified in the first three months of the pilot. Kim stated that 12 had been identified in the 11/1/15-1/31/16 period. Debbie spoke about the care plans not meeting the needs of the person. She stressed the importance of cueing people with brain injury.

Brian commented that it would be helpful for Glyne to let us know the expected timeline for the assessment tool, and offered the Committee's assistance from a TBI perspective. Kyle asked if Glyne could send an email to him regarding the outcome of the meetings with the MCOs. Kyle will also follow-up with Glyne. Brian asked if the data collection will continue. Kim explained that they would not repopulate that data since the answer is now known. The trigger questions will continue to be used in Pre-Admissions Screening. Kyle stated that the Committee will continue monitoring. Lenore commented that the information from the Committee is shared and reviewed with United Healthcare. Kyle commented that if people receive the needed services in the community, it diverts nursing home care, which is more costly in most cases. There was some discussion about capitated rates and that there is a standard capitated rate for all services in the community and nursing homes. Debbie spoke about the safety aspect of living in the community which is a huge issue. Kim commented that the Pre-Admissions Screening nurses look at safety issues.

Ron commented that the VA and the military are seeing a higher significance of TBI reports and the insurance companies are seeing a higher number of claims and monetary awards. He suggested following the data from insurance companies to get the numbers of those with TBIs. Sharon spoke about the even larger number of people with brain injuries not identified as TBI. A question was asked if the same trigger questions are asked of those who had a stroke. Kim explained that the Pre-Admission Screening would show cognitive limitations. Ann spoke about the concern for consistency and that people get needed services. Brian asked about the number of care plans that are reviewed. Kim explained that they do not review care plans and would be done through the MCOs. The MCOs have nurses that do ride-alongs which includes QA and QI. Brian suggested that 50 percent of the 37 care plans be reviewed to see if the services are matching up with the need.

Kim will take this suggestion back to Glyne and Kyle will follow-up. A question was asked if they have seen an increase in telephone calls since the pilot began. Sharon spoke about the large number of telephone calls she gets from people looking for services and there are no resources. Sharon will track this information. Ann and Kyle thanked Kim for today's update.

Ron spoke about a program under the DCVA--Delaware Joining Forces, which is a network of state agencies, and external service providers who proactively work together to provide solutions for military members, veterans and families. The website is: <https://delaware.gov/djf>.

Concussion Protection Legislation Update & Implementation (H.B. 404)

Kyle provided an update on the H.B. 404. This legislation passed the House and Senate and is waiting for the Governor's signature. A summary of the bill is included in the meeting packet. Kyle thanked Jane for her efforts. The amendment adds officials, along with coaches, that need to be educated on concussions. Kyle referenced line 42 of the legislation (handout), in which the Council will provide information sheets to the athletes and parents or guardians. He added that there is a year before implementation.

Kyle opened for discussion the next steps. Brian recommended contacting DIAA and finding out what forms they are currently using. He noted that our training requirements cannot exceed theirs. Kyle will see if DIAA has their forms online. Jane commented that they are using CDC materials. Jane added that Arizona has a whole media DVD-based athlete education package and using this may be an option for us. Brian noted that the law does not require the athlete to watch a video; it requires that they sign a statement saying that they received the information sheet. Kyle commented that we need to discuss how to reach, monitor and track the coaches. Kyle will follow-up with DIAA. Kyle commented that there most likely will be a bill signing event scheduled and will keep everyone informed. Brian recommended having a working group. Kyle added that Representative Heffernan may want to be part of this working group and will follow-up with her. The working group included Jane, Brian, George Meldrum, and Pat Redman (A.I. duPont Hospital). He stated to let him know if anyone else wanted to participate. Jane commented that this was a group effort and thanked Kyle for keeping this legislation moving forward; she also thanked Brian for drafting the legislation and Pat Redmond (A.I. duPont Hospital) for her efforts. Brian asked if the online training was from one source and was it being documented. Kyle commented he did not think there would be a lot of documentation because DIAA trust that their members will comply. Brian commented that since so many different parks and locations are used for the recreational leagues, the logistics become a nightmare. Ron asked if this type of legislation would be considered for those over the age of 18. Kyle stated that we mostly likely will not expand this further.

Brain Injury Trust Fund Update

Kyle stated that we received another \$50,000 in the State budget for the Brain Injury Trust Fund. With the leftover funds from last year, there is about \$95,000 in the Fund. He asked everyone to spread the word. He asked the review team to stay after today's meeting to review some applications. Kyle will send Representative Heffernan a thank you for this funding. Kyle stated that they asked for a reporting the first year, but have not request one since then. Kyle will send out an email about the Brain Injury Trust Fund that can be shared. Ron requested a summary that he would put in the DCVA quarterly newsletter. Jane commented that A.I. duPont Hospital has summer volunteers that could develop with a brochure. Jane will forward the brochure to

DMMA Preliminary Data (no analysis)

Pre-Pilot		11/1/2014 — 1/31/2015				
		Total	%			
Total number of applicants community referrals screened		344				
Number and percentage of such applicants screened with an identified history of TBI		0				
TBI Pilot		11/1/2015 — 1/31/2016				
		Nov	Dec	Jan	Total	%
1	Total Number of applicants community referrals screened	107	97	75	279	
2	Total number of applicants screened with PAE form alone	94	82	47	223	
3	Number and percentage of applicants screened with PAE form alone who were approved	86	76	38	200	71.68 %
4	Number and percentage of applicants screened with PAE form alone who were denied	3	4	2	9	3.23%
5	Number and percentage of applicants screened with both PAE and supplemental TBI assessment who were approved	5	9	7	21	7.53%
6	Number and percentage of applicants screened with both PAE form and supplemental TBI assessment who were denied	0	1	0	1	<1 %
7	Number and percentage of applicants identified with TBI after trigger question asked without identified hx of TBI	3	7	2	12	4.30%
8	Number and percentage of applicants screened with identified hx of TBI	3	2	3	8	2.87%

DMMA Preliminary Data (no analysis)

Pre-Pilot		02/1/2016 — 04/30/2016				
					Total	%
Total number of applicants community referrals screened					333	
Number and percentage of such applicants screened with an identified history of TBI					0	
TBI Pilot		02/1/2016 — 04/30/2016				
		Feb	Mar	Apr	Total	%
1	Total Number of applicants community referrals screened	123	109	101	333	
2	Total number of applicants screened with PAE form alone	92	80	85	257	
3	Number and percentage of applicants screened with PAE form alone who were approved	87	79	84	250	75.08 %
4	Number and percentage of applicants screened with PAE form alone who were denied	5	1	1	7	2.10%
5	Number and percentage of applicants screened with both PAE and supplemental TBI assessment who were approved	15	11	13	39	11.71 %
6	Number and percentage of applicants screened with both PAE form and supplemental TBI assessment who were denied	0	0	3	3	<1 %
7	Number and percentage of applicants identified with TBI after trigger question asked without identified hx of TBI	16	9	12	37	11.11 %
8	Number and percentage of applicants screened with identified hx of TBI	5	2	4	11	3.30%
9	Applicants who withdrew, expired or goal changed	16	18	0	34	10.21 %

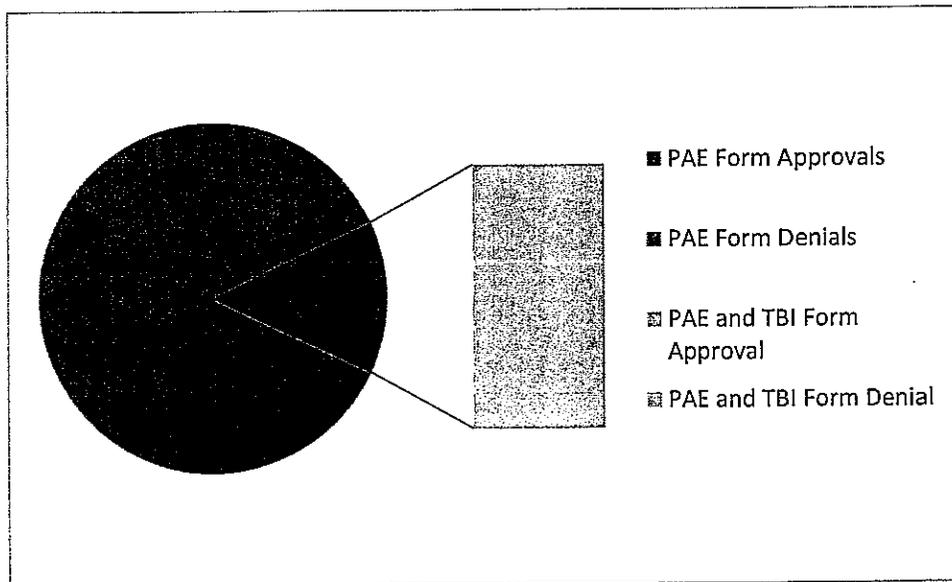
DMMA Preliminary Data (no analysis)

Pre-Pilot 11/1/2014 — 1/31/2015

Referrals	344
TBI Identified	0

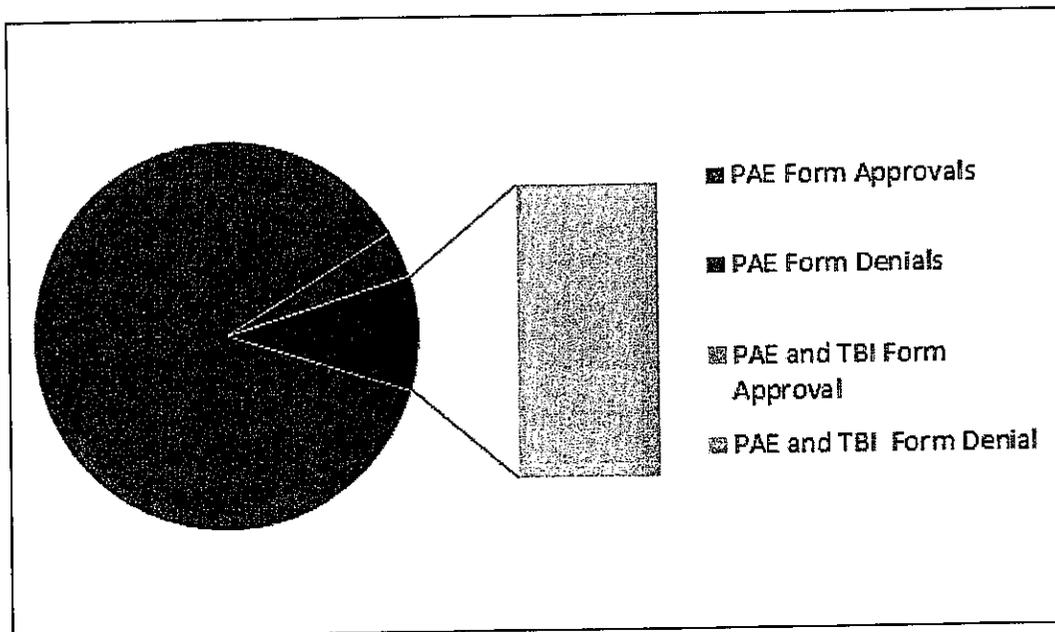
TBI Pilot 2/1/2016 – 04/30/2016

	February	March	April	Total	Percentage
Referrals	123	109	101	333	
Withdrawn/Closed/Pending Assessment	16	18	0	34	10.21%
PAE Form Approvals	87	79	84	250	75.08%
PAE Form Denials	5	1	1	7	2.10%
PAE and TBI Form Approval	15	11	13	39	11.71%
PAE and TBI Form Denial	0	0	3	3	<1%



TBI Pilot 11/1/2015 – 01/31/2016

	November	December	January	Total	Percentage
Referrals	107	97	75	279	
Withdrawn/Closed/Pending Assessment	13	7	28	48	16.48%
PAE Form Approvals	86	76	38	200	71.68%
PAE Form Denials	3	4	2	9	3.23%
PAE and TBI Form Approval	5	9	7	21	7.53%
PAE and TBI Form Denial	0	1	0	1	<1%





STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES

MARGARET M. O'NEILL BUILDING
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DOVER, DE 19901

MEMORANDUM

VOICE: (302) 739-3620
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DATE: October 24, 2016

TO: Ms. Kimberly Xavier, DMMA
Planning & Policy Development Unit

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

RE: 20 DE Reg. 247 [(DMMA Proposed Targeted Case Management Regulation (10/1/16)]

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 adopt a State Medicaid Plan amendment affecting DDDS clients. The proposed regulation was published as 20 DE Reg. 247 in the October 1, 2016 issue of the Register of Regulations.

In a nutshell, "targeted case management" (TCM) would be added as a State Medicaid Plan service with 2 target groups: 1) DDDS clients who are receiving residential services through the DDDS Medicaid waiver; and 2) DDDS clients who are receiving DDDS services and living in their own homes or with their families. The State plans to later file an amendment to the DDDS waiver effective January 1, 2017 to allow the second group to enroll in the waiver. The expanded waiver will be called "the Lifespan Waiver". DDDS will "phase out" the existing "Family Support Specialists" (FSS) who currently provide some case management services to the second group. Instead, DDDS will issue an RFP to obtain some contract agencies who would hire targeted case managers ("Community Navigators") to serve the second group under the waiver. See Supplement 3 to Attachment 3.1-A, p. 1. This approach should result in no additional cost. DDDS clients in the first group (residential clients) would continue to receive case management services from DDDS employees who would be designated "Qualified Support Coordinators".

SCPD has the following observations.

First, the minimum credentials of both the "Community Navigators" (serving non-residential clients) and "Qualified Support Coordinators" (serving residential clients) are weak. Apart from some DDDS training, the standard is as follows:

1. Have an associate's degree or higher in behavioral, social sciences or a related field OR

experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social, or financial needs in accordance with program requirements.

See Supplement 3 to Attachment 3.1-A, Page 6; Supplement 4 to Attachment 3.1-A, Page 6

These individuals are responsible for a host of high-level activities requiring expertise and skills, including monitoring health and welfare; ensuring implementation of service plans; responding and assessing emergency situations; participating in investigations of reportable incidents; assistance with linkages to obtaining services available through Medicaid, Medicare, private insurance, and other community resources; and coordination with MCO representatives, DVR, and educational coordinators. See Supplement 3 to Attachment 3.1-A, Pages 3-6. See also 42 C.F.R. 440.169. It is patent that more robust credentials will be necessary to perform the above functions in a meaningful way. These individuals must be expert in identifying and facilitating access to support services in complex federal, state, and private systems. Under the proposed standard, someone without even a high school diploma and minimal experience in human services will qualify to be hired as a case manager. Contrast the DMMA standards for a Medicaid MCO case manager:

- 1) nurse with 2 years of qualifying experience;
- 2) individual with 4 year degree in human services field plus 1 year experience; or
- 3) high school diploma plus 3 years of qualifying experience.

See 2016 DHSS MCO Contract, §3.7.1.2 [attached]

Second, the level of involvement with the DDDS clients is minimal. A unit of service is "1 month" so compensation is paid based on fulfilling the following de minimis activity once per month: "one (1) service contact that can include face-to-face or telephone contacts with the recipient or on behalf of the recipient". See Attachment 4.19-B, Page 27; Attachment 4.19-B, Page 28. Thus, a case manager meets minimum standards for monthly compensation under the Medicaid program for making a single phone call per month. The combination of case managers with minimal credentials and minimal client contact is inconsistent with the recital that "every jurisdiction in the State will be able to receive high-quality, comprehensive case management services". See Supplement 3 to Attachment 3.1-A, Page 6.

Third, there is no "caseload" benchmark in the Medicaid State Plan Amendment. It would be preferable to include a benchmark such as an upper cap on case manager caseload. Contrast DMMA MCO case management "caseload management" standards, §3.7.1.5.3 of the 2016 DHSS-MCO contract [attached].

Fourth, it would be preferable to have case management provided by State employees rather contracting with private firms with a profit incentive. There may be minimal or no financial benefit to paying a broker agency which charges overhead and then pays case managers

undefined compensation. The fee schedules for government and private providers for case management are the same. See Attachment 4.19-B, Page 27. For example, in practice, MCO case managers have proven much less responsive to client needs than State case managers. Their primary “loyalty” is to their employer, not the State. If CMS prefers a “firewall” between case management and direct service provision, the case managers could be placed under the Office of the Secretary. This was the approach adopted to separate the Long-term Care Ombudsman from DSAAPD since DSAAPD provides direct services in public nursing homes (e.g. DHCI; GBHC).

Fifth, DMMA should consider amending the following reference: “(i)nforms and assists an individual or his or her family to obtain guardianship or other surrogate decision making capability”. See Supplement 4 to Attachment 3.1-A, Page 4. Federal HHS is actively promoting alternatives to guardianship such as supported decision-making. See attachments. Delaware supported decision-making legislation (S.B. 230), co-authored by DHSS, was signed by the Governor on September 15, 2016. Consider the following substitute for the above reference: “(i)nforms and assists an individual or his or her family with surrogate decision making and assistance options, including supported decision-making agreements, powers of attorney, and guardianship.”

Sixth, DMMA should reconsider the following reference: “(f)acilitates referral to a nursing facility when appropriate.” See Supplement 4 to Attachment 3.1-A, Page 4. Placement of DDS clients in nursing homes is highly disfavored. For that reason, DMMA implements the federal PASRR process. Cf. 16 DE Admin Code 5304.1. Moreover, DHSS has been actively prioritizing diversion of individuals from nursing homes through programs such as MFP and the DSHP+. Therefore, it is somewhat “odd” to specifically highlight and prioritize facilitation of referrals to nursing homes in the Medicaid State Plan Amendment.

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

cc: Ms. Rita Landgraf
Mr. Stephen Groff
Ms. Jill Rogers
Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

20reg247 dmma-targeted case management 10-24-16

EXCERPTS: DHS - MEDICAID
MCO CONTRACTS (2016)

to assisting the member in reaching his/her goals as stated in the plan of care.

3.6.4 Clinical Practice Guidelines

3.6.4.1 The Contractor's care coordination program shall utilize evidence-based practice guidelines.

3.6.4.2 The Clinical care coordination program shall be described and included in the contractor's utilization management program description.

3.6.5 Informing and Educating Members

3.6.5.1 The Contractor shall inform all members of the availability of care coordination program activities at all levels and how to access and use care coordination program services.

3.6.6 Informing and Educating Providers

3.6.6.1 The Contractor shall inform providers regarding the operation and goals of the care coordination programs at all levels. Providers shall be given instructions on how to access appropriate services as well as the benefits to the provider.

3.6.7 Care Coordination System Capabilities

3.6.7.1 The Contractor shall maintain and operate a centralized information system necessary to conduct risk stratification. Systems recording program documentation shall include the capability of collecting and reporting short term and intermediate outcomes such as member behavior change. The system shall be able to collect and query information on individual members as needed for follow-up confirmations and to determine intervention outcomes.

3.6.7.2 The Contractor shall work with DMMA to develop Contractor system capacity around promoting provider level care coordination services.

3.6.8 Evaluation

3.6.8.1 The Contractor shall submit the care coordination reports specified in Section 3.21 of this Contract.

3.7 CASE MANAGEMENT FOR DSHP PLUS LTSS MEMBERS

3.7.1 Administrative Standards

3.7.1.1 General

3.7.1.1.1 The Contractor shall provide case management to DSHP Plus LTSS members. This Section of the Contract does not apply to DSHP members nor to DSHP Plus members who are not DSHP Plus LTSS members.

 3.7.1.2 Case Management Staff Qualifications

3.7.1.2.1 The Contractor shall ensure that individuals hired as case managers are either:

3.7.1.2.1.1 Individuals with a Bachelor's degree in health, human, social work or education services with one or more years of qualifying experience; or a high school degree or equivalent and three years of qualifying experience with case management of the aged, including management of behavioral health conditions, or persons with physical or developmental disabilities, or HIV/AIDS population; or

3.7.1.2.1.2 Licensed as an RN; or LPN with two years of qualifying experience with appropriate supervision in accordance with Delaware law (see 24 DE Admin Code 1900).

3.7.1.2.2 The Contractor shall ensure that case managers have:

3.7.1.2.2.1 Experience interviewing and assessing member needs;

3.7.1.2.2.2 Knowledge and experience regarding caseload management and casework practices;

3.7.1.2.2.3 Knowledge regarding determining eligibility for DHSS programs;

3.7.1.2.2.4 Knowledge regarding Federal and State law as it applies to DHSS programs;

3.7.1.2.2.5 The ability to effectively solve problems and locate community resources;

3.7.1.2.2.6 The ability to collaborate with Caregivers, involved State agency representatives and providers;

3.7.1.2.2.7 Good interpersonal skills;

3.7.1.2.2.8 Fundamental background in cultural and socio-economic diversity; and

3.7.1.2.2.9 Knowledge of the needs and service delivery system for all populations in the case manager's caseload.

- 3.7.1.4.4.5 Cultural Competency;
- 3.7.1.4.4.6 Medical/behavioral health issues; and/or
- 3.7.1.4.4.7 Medications – side effects, contraindications and poly-pharmacy issues.

3.7.1.4.5 Training may be provided by external sources, for example by:

- 3.7.1.4.5.1 Consumer advocacy groups;
- 3.7.1.4.5.2 Providers (for example, medical or behavioral health); or
- 3.7.1.4.5.3 Accredited training agencies.

3.7.1.4.6 The Contractor shall ensure that a staff person(s) is designated as the expert(s) on housing, education and employment issues and resources. This expert must assist case managers with up-to-date information designed to aid members in making informed decisions about their independent living options.

3.7.1.5 Caseload Management

3.7.1.5.1 The Contractor shall have an adequate number of qualified and trained case managers to meet the needs of DSHP Plus LTSS members.

3.7.1.5.2 The Contractor must ensure that newly Enrolled DSHP Plus LTSS members are assigned to a case manager immediately upon Enrollment. The case manager assigned to a special subpopulation (e.g., members with HIV/AIDS or ABI or PROMISE participants) must have experience or training in case management techniques for such population.



3.7.1.5.3 The Contractor must maintain case manager staffing ratios of:

3.7.1.5.3.1 1:120 for members living in nursing facilities;

3.7.1.5.3.2 1:60 for members receiving HCBS (living in their own home or assisted living facility); and

3.7.1.5.3.3 1:30 for members receiving services under the Money Follows the Person (MFP) program.

3.7.1.5.4 If the Contractor utilize the services of agencies to provide case management services for DSHP Plus LTSS members with HIV/AIDS who meet acute hospital LOC;

- 3.7.1.5.4.1 The agency's case manager staffing ratio must be 1:60 members; and
- 3.7.1.5.4.2 The Contractor's case manager staffing ratios must be 1:100 members.
- 3.7.1.5.5 The Contractor shall ensure that case management is provided at a level dictated by the complexity and required needs of the member, including coordination needed to implement a comprehensive plan of care that addresses all of the member's needs.
- 3.7.1.5.6 The Contractor shall ensure that each case manager's caseload does not exceed a weighted value of 120. The following formula represents the maximum number of members allowable per case manager:
 - 3.7.1.5.6.1 For nursing facility members, a weighted value of 1 is assigned. Case managers may have up to 120 institutionalized members ($120 \times 1 = 120$).
 - 3.7.1.5.6.2 For HCBS members (living in their own home or assisted living facility), a weighted value of 2 is assigned. Case managers may have up to 60 HCBS members ($60 \times 2 = 120$).
 - 3.7.1.5.6.3 For MFP members, a weighted value of 4 is assigned. Case managers may have up to 30 MFP members ($30 \times 4 = 120$).
 - 3.7.1.5.6.4 If a mixed caseload is assigned, there can be no more than a weighted value of 120. The following formula is to be used in determining a case manager's mixed caseload:
 - 3.7.1.5.6.4.1 $(\# \text{ of NF members} \times 1) + (\# \text{ of HCBS members} \times 2) + (\# \text{ of MFP members} \times 4) = 120 \text{ or less}$
 - 3.7.1.5.6.5 The Contractor must receive authorization from the State prior to implementing caseloads whose values exceed those specified above. The Contractor may establish lower caseload sizes at its discretion without prior authorization from the State.

3.7.1.6 Accessibility

- 3.7.1.6.1 The Contractor shall provide members and/or member representatives with adequate information in order to be able to contact their case manager or the Contractor's member services information line for assistance, including what to do in cases of emergencies and/or after hours.

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ACL BLOG

Preserving the Right to Self-determination: Supported Decision-Making

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By Aaron Bishop, Commissioner, Administration for Intellectual and Developmental Disabilities, and Edwin Walker, Deputy Assistant Secretary for Aging

For many years, state courts have routinely assigned guardians to people with intellectual and developmental disabilities as they became adults. Older adults with dementia-related disorders also frequently have been assigned guardians.

The trouble with guardianship is that it is a legal process. A court deems a person incapacitated or legally incompetent and assigns a substitute decision-maker for that person. Guardianship laws vary by state, but in some states, guardians are given the authority to make all financial, legal, and personal decisions on behalf of another person. Essentially, the person can lose ALL of his or her rights to independence, autonomy, and decision-making.

This approach assumes that people with disabilities and older adults are incapable of making decisions. That is simply not the case.

The goal of the Administration for Community Living is to maximize the independence and well-being of older adults and people with disabilities. We are proud to be a leader in exploring alternatives to guardianship. We believe supported decision-making poses the most promising and flexible model.

Supported decision-making starts with the assumption that people with intellectual and developmental disabilities and older adults with cognitive impairment should retain choice and control over all the decisions in their lives. It is not a program. Rather, it is a process of working with the person to identify where help is needed and devising an approach for providing that help. Different people need help with different types of decisions. For some, it might be financial or health care decisions. Others may need help with decisions surrounding reproductive rights or voting. Some may need help with many types of decisions, while others need help with only one or two.

The solutions also are different for each person. Some people need one-on-one support and discussion about the issue at hand. For others, a team approach works best. Some people may benefit from situations being explained pictorially. With supported decision-making the possibilities are endless.

The key is that the process is centered on the person to whom the decisions apply, and it enables the person to make decisions based on his or her wants and preferences. Supported decision-making keeps control in the hands of the individual, while providing assistance in specific ways and in specific situations that are useful to the person.

We know on a case-by-case basis and anecdotally that supported decision-making works, and it appears to have the potential to provide a significant improvement to current guardianship arrangements. However, it has not been formally tested, which can make it difficult for states to adopt the practice.

To address that challenge, the Administration on Intellectual and Developmental Disabilities and the Administration on Aging, two program components of the Administration for Community Living, jointly awarded a cooperative agreement to Quality Trust for Individuals with Disabilities to build a national training, technical assistance, and resource center to explore and develop supported decision-making as an alternative to guardianship. The resource center will gather and disseminate data on the various ways in which supported decision-making is being implemented and generate research in the area. Our goal is that

the information collected during the period of this cooperative agreement will lead to a model that will help states as they consider alternatives to guardianship.

We are excited by the possibilities this work may generate. It is another step toward ensuring all people are treated with dignity and respect throughout their lives. It is another step toward a vision for the future that includes a collective recognition that the right to self-determination and independence are fundamental for everyone. And ultimately, it offers the promise of new opportunities for people with disabilities and older adults to live and thrive in the communities of their choice.

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Update: A Message from Commissioner Bishop

February 13, 2015

Thank you to all our readers who joined this discussion and shared their personal perspectives. The range and diversity of stories, experiences, and responses shows there is no one-size-fits-all solution to this important issue. Many of the concerns shared here highlight exactly the sort of questions that the National Resource Center for Supported Decision Making seeks to explore.

As Deputy Assistant Secretary Walker and I noted in our blog, when it comes to supported decision-making, no two situations are exactly alike. The Administration for Community Living (ACL) recognizes that people with disabilities and older Americans sometimes experience challenges in understanding and communicating their preferences and needs—and, as your stories illustrate, family members and caregivers often play a critical role in ensuring that those preferences are honored and needs are met. Your stories also demonstrate the dangers that can arise when guardianship is viewed as the default option for those who only need support with making a few decisions.

ACL promotes the concept of supported decision-making not because it is the only option, but because it offers flexibility to provide as much assistance as needed—including total assistance, when that is appropriate—while also ensuring that the right to self-determination is preserved for each individual.

We thank you again for your contributions to this important discussion and hope you will keep the comments coming. The feedback you provide will help us think about, and talk about, this issue more clearly going forward.

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Replies

Name	Date	Comment
Silvia	January 29, 2015	This is a great and timely project—thank you! Just a couple of additional factors that would be great to consider as research is done. 1st, consider how the various options for partial decision-making authority impact on the person with a disability and those people in their lives who can/do provide assistance and decision support or actual transferred decision-making. That is, does a family member have to work through 2, 4 or 10 different forms and authorization processes for different agencies, government levels, and topical areas to avoid being an overall legal guardian? Does each agency or authority ignore other kinds of authorizations? 2nd, consider the impact or additional factors that arise in the context of the kind of passive enrollment processes that are commonly occurring in Medicare and Medicaid dual-eligible integration pilots, for example, where PWD are enrolled into managed care plans unless they hear otherwise from a beneficiary or “authorized representative.” Thanks much
Cathy	January 29, 2015	My son self determines everything about his life. He is labeled ID. I could not imagine his life if someone else chose for him. He is well rounded and not pigeon holed.



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Administration for Community Living

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A New Path: 2016 PCPID Report to the President Now Available

The President's Committee for People with Intellectual Disabilities (PCPID) 2016 Report is now available online.

The report, *Strengthening an Inclusive Pathway for People with Intellectual Disabilities and their Families*, recognizes the "great strides" made since President John F. Kennedy established a blue-ribbon panel to address the needs of people with intellectual disabilities and their families and PCPID Chairman Jack Brandt notes that, "despite these advances, the trajectory for a person with an intellectual disability remains limited."

The report examines four key areas to determine how a new path can be forged for people with intellectual disabilities to be included in all aspects of society:

- Early family engagement to support high expectations for students with disabilities;
- Federal education policies and enforcement strategies to end segregation in schools;
- Transition to adulthood as a critical timeframe for establishing paths to higher education and career development; and
- Self-determination and supported decision-making starting in early childhood and continuing throughout the individual's lifespan.

Brandt is the new chairman for PCPID and is appreciative of the efforts of the former chair, Julie Petty. Brandt says, "Julie's leadership of PCPID took the organization to a new and positive place. I appreciate her outstanding service to PCPID."

PCPID serves in an advisory capacity to the President of the United States and the Secretary of Health and Human Services (HHS) promoting policies and initiatives that support independence and lifelong inclusion of people with intellectual disabilities in their respective communities. The committee includes representatives from several federal agencies and 12 citizen members.

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Administration for Community Living • Washington, DC 20201

Contractor Licensing

Contractor Licenses issued by New Castle County are valid for contractors working in unincorporated New Castle County. All individuals and businesses that provide construction and building improvement services are required to obtain a New Castle County contractor license, in addition to the State of Delaware business license. Those that provide work requiring building permits need a contractor license with permit endorsement.

To obtain a contractor license packet or apply online for non-permit endorsed contractors, use the links to the left. Additional license information is provided in the Contractor Licensing EZ Guide.

Search Licensed Contractors in New Castle County

You can search on line to see if your contractor is licensed with our [Contractor License Search](#) . The search results will provide the Licensed Contractor and the authorized trades. The trade license definitions are defined in the Contractor Licensing EZ Guide.

Code Books Required

[Chapter Six](#) of the New Castle County Code, known as the NCC Building Code, and its [appendices](#) contain amendments to the adopted codes and is available for download. Additionally, all contractors are required to obtain of the current NCC adopted codes applicable to the applicant's trade. The 2015 ICC Code Books are available for purchase from the Department of Land Use and the ICC website.

FAQs

How do I determine if my job is located in New Castle County's jurisdiction? Contractor Licenses issued by New Castle County are valid for contractors working in unincorporated New Castle County. To determine if your job is located in unincorporated New Castle County, click [Parcel Search](#) to look up the address details. From the Parcel Details page, the municipal information is listed in the top section of the details.

My job does not require a permit from New Castle County. Do I still need a contractor's license? All persons engaging in any aspect of construction

Contact Us

Land Use Department [Email](#)

New Castle County
Government Center
87 Read's Way
New Castle, DE 19720

Ph: 302-395-5555 (general questions and complaints)
Ph: 302-395-5400 (planning and permitting questions)
Fx: 302-395-5587

Hours

Monday - Friday
8 a.m. - 4 p.m.

[Staff Directory](#)

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Contractor Licensing
Questions, please contact
302-395-5420 or e-mail
Permits@nccde.org

activity, as defined by Sector 23 - Construction of the current addition of the North American Industry Classification System (NAICS) code, excluding those solely engaged in subdivision and land development (Yr 2002 NAICS 2372), electrical contractors (must be licensed with the State of Delaware as an electrician), heavy utility construction in the Delaware Department of Transportation (DeIDOT) right of way, and maintenance employees of state-owned facilities, are defined as contractors requiring a license.

You can perform a keyword search of the [NAICS database](#) and also view categories within Sector 23 - Construction.

What type of Contractor License do I need? New Castle County offers two license types: Permit endorsed license and a Non-Permit endorsed license.

- Non-Permit endorsed licenses are valid to perform construction activity defined by Sector 23 of the North American Industry Classification System (NAICS) code that does not require a permit from our jurisdiction or fall under HVACR and plumbing work requiring separate licensing.
- Permit endorsed licenses may be obtained for building and utility work. There are different license categories based on the work to be performed in each area. Review the contractor licensing requirement packet for complete details and click the Contractor License EZ Guide.



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DEPARTMENT OF JUSTICE
STATE OFFICE BUILDING
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WILMINGTON, DELAWARE 19801

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CHARLES M. OBERLY, III
ATTORNEY GENERAL

September 13, 1989

RECEIVED

Thomas P. Eichler, Secretary
Department of Health and Social Services
Delaware State Hospital
1901 N. duPont Highway
New Castle, DE 19720

SEP 20 1989

DIRECTOR'S OFFICE
D. M. R.

Re: Liability of Guardian
Opinion No. 89-1018

Dear Secretary Eichler:

You have asked the following questions as they relate to adults for whom guardians have been judicially appointed due to the adults' incompetence.

1. May a guardian be held personally liable for damages caused by the negligence or intentional misconduct of his ward?

2. May a guardian be held personally liable for the cost of his ward's care by statute, specifically 29 Del. C. Section 7940 or 16 Del. C. Section 5520? Would the guardian's obligation be greater than that of relatives or family members?

3. May a guardian be held personally liable for the cost of the ward's care if the State were to discontinue services and/or placement? Would the guardian's obligation be different from other relatives or family members in this situation?

4. Are there any other legal bases for finding a guardian personally financially liable for his ward?

We respond as follows.

"A guardian cannot be held personally liable for damages caused by the negligence or intentional misconduct of his ward solely by virtue of his status as guardian. The guardian himself must have behaved in a negligent or intentionally wrong manner before he may be found liable. That is, a guardian must have been aware of the likelihood of his ward's engaging in the conduct causing injury and nonetheless have failed to properly supervise his ward. Smart v. United States, 111 F. Supp. 907 (W.D. Okla. 1953), aff'd, 207 F.2d 841 (10th Cir. 1953). These principles apply equally to your next inquiry.

Under the common law, a guardian is not responsible for the costs of his ward's care simply by virtue of his relation as guardian.¹ District of Columbia v. H.J.B., D.C. App., 350 A.2d 285, 292 (1976). Unless he agrees otherwise, a guardian of an incompetent adult is entitled to reimbursement for the costs of the ward's care from the assets of the ward.¹ In re Griffith, Del. Ch., 93 A.2d 920 (1953); In re Grcich, Pa. Supr., 423 A.2d 347 (1980). There is nothing in Delaware's statutory laws which alters these principles.

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This is in contrast to the guardian of a minor ward. The guardian of a minor ward may have a duty to support his ward.

Sixteen Del. C. sec. 5520 imposes liability for the costs of the care of a client of the Stockley Center upon only the client himself. It imposes no liability upon the guardian of such a client. Twenty-nine Del. C. sec. 7940 reads in relevant part:

[a]ny person committed to or accepting the services of any hospital, home, clinic or other facility of the Department [of Health and Social Services] and his spouse, parents or children in the order named, except for persons committed to a prison or correctional institution, shall at all times be jointly and severally liable for the full cost of the care, treatment or both provided him, except as may be specifically set forth in this section.

Thus, by its own terms, 29 Del. C. sec. 7940 does not impose liability upon any party based solely upon that party's status as guardian. If the guardian is, in addition, the ward's spouse, parent or child, the guardian may be liable based on his familial status to the extent provided by 29 Del. C. sec. 7940. The named relatives of a ward receiving the services of a facility of the Department of Health and Social Services would be liable for the costs of the ward's care incurred during the ward's minority and the first five years of the ward's care or treatment after the age of 18, up to 10% of each liable family member's annual disposable income. 29 Del. C. sec. 7940(a), (c). Finally, 13 Del. C. Section 503 provides:

[e]xcept as expressly provided in Section 501 and Section 502 of this title, the duty to support a

poor person unable to support himself rests upon his spouse, parents, or children, in that order, subject to Section 504 of this title as to expenses described therein. If the relation prior in order shall not be the able, the next in order shall be liable, and several relations of the same order, shall, if able, contribute according to their means.²

It is evident, then, that the statutory liability of the ward's named relatives exceeds that of the ward's guardian.

As stated above, the guardian of an incompetent adult is entitled to reimbursement for his ward's care from the estate of the ward. The corollary of this principle is that a guardian is not required to expend his own assets for his ward's care. Thus, if the State were to discontinue services to the ward, the guardian would not be required to arrange for services for the ward at his own expense. As a fiduciary, a guardian is obligated to act in his ward's best interests and use the ward's available resources for the ward's care. However, the guardian is not obligated to use his own resources to provide for the ward. Family members owe no legal duty of care to their adult

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The broad language of this statute has not been comprehensively construed by the Delaware courts. The limited case law on this subject suggests that the State or its agencies have no standing to bring an action on behalf of the "poor person"; only the poor person himself may be entitled to bring the cause of action. Ziegler v. Fowke, No. C-3834/D-9724, Del. Fam., Gallagher, J. (July 26, 1983).

relatives, other than that imposed by 29 Del. C. sec. 7940 and 13.
3
Del. C. sec. 503.

Finally, you have asked whether there are any other legal bases for holding a guardian personally liable for the costs of his ward's care. ~~A guardian who contracts for services for his ward is personally liable for the costs of the services.~~ 2 S. Williston, A Treatise on the Law of Contracts sec. 314, at 521-522 (3d ed. 1959). He is entitled to reimbursement for the costs of the services from the ward's assets, but to the extent that the ward's assets fall short, the guardian must pay the difference. The guardian may avoid such liability only if the other party to the contract agrees to look only to the assets of the ward for payment. Id. sec. 314 at 523.

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Thirteen Del. C. sec. 503 provides: "Except as expressly provided in sec. 501 and sec. 502 of this title, the duty to support a poor person unable to support himself rests upon his spouse, parents, or children, in that order, subject to sec. 504 of this title as to expenses described therein. If the relation prior in order shall not be able, the next in order shall be liable, and several relations of the same order, shall, if able, contribute according to their means."

Thomas P. Eichler, Secretary
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If you have any additional questions, please do not hesitate
to contact us.

Very truly yours,

Michael F. Foster

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State Solicitor

Ann Woolfolk

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APPROVED:

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