

MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Legislative, Regulatory, and Executive Initiatives

Date: October 9, 2007

I am providing my analysis of twelve (12) legislative, regulatory and executive initiatives in anticipation of the October 11 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. DOT Final Refueling Assistance Regulation [11 DE Reg. 517 (October 1, 2007)]

The Department of Transportation issued proposed regulations in September of 2006 to require self-service gas stations to provide signs advertising the availability of refueling assistance for drivers with disabilities consistent with Title 6 Del.C. §2912. The SCPD submitted the attached October 10, 2006 comments. The Council endorsed the concept of the proposed regulations subject to substituting “people first” language for “handicapped”. The Department has now published final regulations which recite that “handicapped” was replaced with “persons with disabilities” and that the term “gasoline” was replaced by “motor fuels”.

I have the following observations.

First, although the Department describes incorporation of the above amendments into the regulation, this has not occurred. The Register (at p. 518) recites that “no changes were made to the regulation as originally published in the September 2006 issue of the Register...” Moreover, the Register provides a link to the official final regulation which likewise contains no amendments. Therefore, at a minimum, the Department should consider publishing an “erratum” in the Register.

Second, H.B. No. 83 was enacted in June, 2007. It imposes more comprehensive refueling assistance standards on service stations, including phasing in “calling devices” to alert gas station attendants that a motorist with a disability is soliciting assistance. It would be preferable for DOT to issue revised regulations to incorporate the new standards. This would facilitate service station knowledge of the change in law and compliance.

I recommend that the Council share the above observations and recommendations with the DOT with a copy to the publisher of the Register of Regulations.

2. Delaware Psychiatric Center Task Force [Exec. Order 100, 11 DE Reg. 519 (October 1, 2007)]

The News Journal has been publishing a series of critical articles concerning the Delaware Psychiatric Center since July, 2007. In response, the Legislature established a Delaware Psychiatric Center Investigative Committee which convened multiple hearings to obtain perspective on DPC. After publication of many articles, the Governor established her own task force to assess DPC. For background, I am attaching the following: August 18, September 18 and October 9 News Journal articles; and excerpts from the Task Force Website which includes the opening remarks of Secretary Meconi. The Task Force meeting occurred on September 17 and the next meeting is scheduled to occur on October 16 at the Springer Building at DPC. A report is due to the Governor by December 15, 2007.

I have the following observations.

First, as the articles reveal, the News Journal remains skeptical of the membership and likely outcome of the Task Force. As the September 18 article indicates, neither the DSAMH Director nor the DPC Director attended the initial meeting despite being convened at DPC. This does not bode well for the viability of the Task Force's assessment.

Second, the DLP submitted testimony (with recommendations) to both the Legislature's Investigative Committee and the Task Force. The SCPD voted to endorse the DLP's commentary. Some of the recommendations would have budgetary implications so it is important to share input to promote prospects for consumer-oriented Task Force recommendations being incorporated into the Governor's proposed FY 09 budget.

Third, in the attached September 17 opening remarks, Secretary Meconi indicates that he shared four (4) handouts also provided to the Legislature's Investigative Committee. The materials provide an overview of DPC, describe criminal background checks, offer certification and accreditation information, and cover the PM 46 process. I recommend that the Council solicit a copy of the handouts which could prove useful in preparation of testimony for the November 13 budget hearing.

Fourth, I recommend that the Council monitor the progress of the Task Force and consider submission of supplemental input to influence the Task Force's deliberations.

3. Child Poverty Task Force [Executive Order 101, 11 DE Reg. 520 (October 1, 2007)]

The Governor issued this executive order on August 29, 2007. It establishes a large (25-member) task force charged with issuing a report within one (1) year. There are no members overtly representing or focusing on the interests of children with disabilities. The report is expected to include recommendations and strategies to achieve a 50% reduction in child poverty by June 30, 2017.

As background, the order notes the following: 1) Delaware's child poverty rate has been increasing since 2002; 2) child poverty is linked to premature deaths from infectious diseases and

high school drop-outs; and 3) some states and municipalities have adopted commitments to reduce child poverty within their respective jurisdictions by 50% within ten (10) years.

I have the following observations.

First, consistent with the attached October 2006 News Journal article, Delaware's high school graduation rate is below the national average. Only 7 out of 10 white students and half of black and Hispanic students graduate from high school. The article also notes that drop-outs are more likely to be living in poverty and 32% of interviewed drop-outs left school to get a job. It is therefore important that the Task Force address strategies to promote graduation.

Second, consistent with the attached Kids Caucus fact sheet, the percentage of children without health insurance rose from 7.5% in 2000-2002 to 10.7% in 2004-2006. An estimated 19,050 children in Delaware are uninsured, 55% of whom are eligible for but not enrolled in Medicaid or CHIP. It is therefore important that the Task Force recommend options to expand health care coverage.

Third, families with members with disabilities are disproportionately indigent. Consistent with the attached July 20, 2007 News Journal article, the Delaware Healthy Delawareans survey found that two thirds (2/3) of persons with disabilities live in a household with less than \$25,000 in annual income.

Since the SCPD's statutory charge [Title 29 Del.C. §8734] includes serving as a source of expertise on strategies to improve the lives of Delawareans with disabilities, I recommend that the Council offer its assistance to the Task Force in the context of disability-related issues.

4. DSS Proposed Food Stamp Notice Regulation [11 DE Reg. 443 (October 1, 2007)]

The Division of Social Services proposes to adopt a few discrete amendments to its standards applicable to notices of termination or reduction of food stamp benefits.

I have the following observations.

First, it is difficult to determine the rationale for the revisions. The APA contemplates that agencies will describe the "substance" and "issues" underlying a proposed regulation:

The notice shall describe the nature of the proceedings, including a brief synopsis of the subject, substance, issues, possible terms of the agency action, a reference to the legal authority of the agency to act and reference to any other regulations that may be impacted or affected by the proposal.

Title 29 Del.C. §10115(a)(1).

In contrast, DSS provides no information describing the amendments or rationale for proposal. This undermines the public's ability to comment on the initiative. DSS may wish to

prospectively consider including more information about the substance and issues underlying proposed amendments.

Second, §9006.3 directs that no notice of adverse action be provided to beneficiaries under certain circumstances. DSS proposes to delete the following basis for withholding notice: “DSS mail has been returned by the post office indicating no known forwarding address”. The underlying federal regulation [7 C.F.R. 273.13 (attached)] includes the following standard:

(c) *Optional notice.* The State agency may, at its option, send the household an adequate notice as provided in paragraph (b)(3) of this section when the household’s address is unknown and mail directed to it has been returned by the post office indicating no known forwarding address.

The federal Department of Agriculture has provided additional direction through the attached excerpt from a Question and Answer Guidance document on its website. It recites as follows:

Question K-8

Suppose the local office has lost contact with the household. Perhaps the post office returned mail. What should the local office do?

Answer K-8

Until 7 C.F.R. 273.12©)(3), the Request for Contact, becomes effective, the state agency must issue an advance or adequate notice of adverse action and terminate the household’s participation. However, before doing so, it would be prudent to try to locate the household in another way, since the notice will probably never reach the household.

When 7 C.F.R. 273.12©)(3) becomes effective, the state agency will have to issue a request for contact and then issue a notice before terminating the household’s participation. But again, another attempt, such as a telephone call, would be prudent.

Either way, the state agency has the option of sending an adequate, rather than advance, notice (please see 7 C.F.R.273.13©).

The federal standards ostensibly encourage attempts to notify a household of adverse action and offer DSS the discretion to issue written notice even when prior mail has been returned by the post office with no forwarding address. Since the proposed amendment favors beneficiaries, it merits endorsement.

Third, DSS proposes to amend a reference in §9006.3(10) to correct a citation by substituting DSSM 7004.1 for DSSM 7000:

Do not provide individual notices of adverse action when:

(10) Converting a household from cash repayment to benefit reduction as a result of failure to make agreed upon repayment as discussed in DSSM ~~7000~~ 7004.1.

Substantively, the concept underlying this provision is unobjectionable since it is based on 7 C.F.R. §273.13(b)(10). Moreover, since there is no discrete §7000 (only a chapter 7000), it makes sense to amend the citation. However, since DSSM 7004.3 addresses failure to comply with a repayment agreement in much more detail than DSSM 7004.1, DSS may wish to consider amending the reference to either refer solely to “DSSM 7004.3” or to both “DSSM 7004.1 and DSSM 7004.3”.

I recommend sharing the above observations with the Division.

5. DMMA Prop. Nursing Home Reimbursement Regulation [11 DE Reg. 427 (October 1, 2007)]

The Division of Medicaid and Medical Assistance proposes to amend its Medicaid State Plan in the context of long-term care facility reimbursement. The Division indicates that it is not effecting substantive changes to standards and only clarifying current practices.

I have the following observations.

First, the Division establishes its discretionary authority for creating rates for public facilities. The regulation provides DMMA with the option of either: 1) including public facilities with private facilities when compiling cost information to arrive at a base rate; or 2) simply using public facility costs to arrive to a base rate. At 428-429. This discretion would ostensibly benefit the State which could then adopt the approach most financially beneficial to public facilities. This merits endorsement.

Second, the DMMA Director is granted the authority to waive State Plan reimbursement limits “if a circumstance exists that could negatively affect the health, safety and welfare of residents in Delaware if the provision is not waived.” At p. 439. This concept is similar to one endorsed by the Council authorizing the State to provide additional reimbursement to pediatric nursing homes to assure that a child’s health status is not jeopardized.” See commentary at 11 DE Reg. 314 (September 1, 2007). My only concern with the proposed language is that it is literally limited to “residents in Delaware”. Sections VII (p. 441) and IX (p. 442) contemplate reimbursement to out-of-state facilities (e.g. Vorhees). To ensure that the DMMA Director’s authority to waive standards could extend to out-of-state facilities, it would be preferable to substitute “facility residents” for “residents in Delaware”. This would achieve consistency with Section IX which grants DMMA the option of providing additional reimbursement to both in-state and out-of-state facilities.

Third, the balance of the proposed amendments are essentially clarifications to promote consistency among the regulations. I did not identify any concerns in this context.

I recommend that the Council share the above observations with DMMA.

6. DOE Elementary School Counselor Regulation [11 DE Reg. 404 (October 1, 2007)]

The Department of Education proposes to revamp its certification standards applicable to elementary school counselors.

I have the following observations.

First, the standards are similar to existing criteria. To qualify for the certificate, a new applicant must either: 1) have a Masters degree in Elementary School Counseling; or 2) have a Masters degree in another field plus 27 hours of specified graduate course work. There is also an experience requirement of either 3 years in an elementary school setting, 3 years of equivalent experience, or 1 year elementary school counseling internship.

Second, the DOE may wish to reconsider the scope of the criteria which authorize the applicant to qualify based on “a Masters degree in any content area” plus 27 semester hours of specified course work. There is no definition of “content area”. Under this standard, even a librarian (school library media specialist) or PE teacher could qualify as a school counselor if the coursework standards were met. Reasonable persons might differ on whether this is too loose a standard.

Third, the title of “elementary school counselor” is somewhat narrow. Section 1.0 recites as follows: This certification is required for grades 1 to 6, and is valid in grades 5 to 8 in a Middle Level School”. The DOE should consider whether this could be interpreted as permitting individuals to serve as “counselors” in middle school with no counseling certificate. Based on the DOE’s proposed Secondary School Counselor regulations, 11 DE Reg. 420, 422, §1.1, I infer that the Department expects a middle school counselor to have either an elementary school counselor or secondary school counselor certificate. However, there is no regulation which literally requires an individual serving as a counselor in a middle school to have any counseling certificate. For clarity, the DOE should consider adding a regulatory note or adding the following sentence to the end of §1.1: A Middle Level School counselor must have either an elementary or secondary school counselor certificate.

Fourth, since the DOE contemplates that an individual with an elementary school counseling certificate can successfully work in a middle school, it may wish to consider amending the experience standard (§4.2.1) to read “(a) minimum of three years in an elementary or middle school setting”.

Fifth, for grammatical reasons, the DOE should consider substituting “satisfactorily completed” for “satisfactory completion of” in §4.1.2. There is a lack of parallel form. All standards in §4.0 are in verb form (e.g. “has satisfied”; “graduated”; “has met”).

I recommend that the Council share the above observations with the DOE, SBE, and Professional Standards Board.

7. DOE Secondary School Counselor Regulation [11 DE Reg. 420 (October 1, 2007)]

The Department of Education proposes to revamp its certification standards applicable to secondary school counselors.

I have the following observations.

First, the standards are similar to existing criteria. To qualify for the certificate, a new applicant must either: 1) have a Masters degree in Elementary School Counseling; or 2) have a Masters degree in another field plus 27 hours of specified graduate course work. There is also an experience requirement of either 3 years in a secondary school setting, 3 years of equivalent experience, or 1 year secondary school counseling internship.

Second, the DOE may wish to reconsider the scope of the criteria which authorize the applicant to qualify based on “a Masters degree in any content area” plus 27 semester hours of specified course work. There is no definition of “content area”. Under this standard, even a librarian (school library media specialist) or PE teacher could qualify as a school counselor if the coursework standards were met. Reasonable persons might differ on whether this is too loose a standard.

Third, the title of “secondary school counselor” is somewhat narrow. Section 1.0 recites as follows: This certification is required for grades 9 to 12, and is valid in grades 5 to 8 in a Middle Level School”. The DOE should consider whether this could be interpreted as permitting individuals to serve as “counselors” in middle school with no counseling certificate. Based on the DOE’s proposed Elementary School Counselor regulations, 11 DE Reg. 404, 406, §1.1, I infer that the Department expects a middle school counselor to have either an elementary school counselor or secondary school counselor certificate. However, there is no regulation which literally requires an individual serving as a counselor in a middle school to have any counseling certificate. For clarity, the DOE should consider adding a regulatory note or adding the following sentence to the end of §1.1: A Middle Level School counselor must have either an elementary or secondary school counselor certificate.

Fourth, since the DOE contemplates that an individual with a secondary school counseling certificate can successfully work in a middle school, it may wish to consider amending the experience standard (§4.2.1) to read “(a) minimum of three years in a secondary or middle school setting”.

Fifth, for grammatical reasons, the DOE should consider substituting “satisfactorily completed” for “satisfactory completion of” in §4.1.2. There is a lack of parallel form. All standards in §4.0 are in verb form (e.g. “has satisfied”; “graduated”; “has met”).

I recommend that the Council share the above observations with the DOE, SBE, and Professional Standards Board.

8. DOE Proposed School Police Relations Regulation [11 DE Reg. 399 (October 1, 2007)]

The Department of Education proposes to revamp its regulations covering reporting of school-related crimes. In a nutshell, public schools must maintain MOUs with local law enforcement agencies, administrators responsible for reporting crimes and conduct must be trained, and schools which fail to comply with reporting requirements will be designated as “persistently dangerous schools”. The latter designation activates the attached 16 DE Admin Code 608 which allows students to transfer to “safe” schools and requires the school to develop a remedial plan.

I have the following observations.

First, §4.2 generally contemplates that DOE will train administrators in reporting standards and procedures. However, it includes an authorization for someone who has already completed DOE training to train others. A potential weakness with this approach is that it omits any time line. For example, if someone completed the DOE training 5 years ago, §4.2 would literally still allow that individual to serve as an official trainer irrespective of current qualifications. The DOE may wish to either: 1) include a time standard (e.g. trained within the past 3 years); or 2) clarify that the school must submit the name to the DOE in advance of the training for DOE approval.

Second, §6.0 may be “overbroad”. It lists 12 types of conduct which it mandates be reported to the DOE. The 12 types of conduct are described as “(i)n addition to those school crimes required to be reported pursuant to statute”. The list “muddies the waters” somewhat since it may include crimes which must be reported by statute. For example, production of child pornography [Title 11 Del.C. §1109] is classified as a violent felony [Title 11 Del.C. §4201©)] which must be reported by statute [Title 14 Del.C. §4112(a)(13) and (b)]. Moreover, some of the types of conduct triggering mandatory reporting are relatively minor property offenses (e.g. criminal mischief). In contrast, the statute covering mandatory reporting only mentions offenses against the person. If the Legislature wished the Department to mandate reporting of such minor offenses, it would logically have included them in the statute. Their absence suggests that the DOE is imposing requirements on schools in excess of legislative intent. The burden on districts may be quite substantial. For example, “disorderly conduct” [Title 11 Del.C. §1301] is broadly defined as causing “annoyance” by “making an unreasonable noise or an offensively coarse utterance”. With teenagers, schools will be required to report a huge volume of bantering or face designation as a “persistently dangerous school”. The DOE should consider deletion of property offenses (e.g. criminal mischief) and other minor, high incidence offenses (e.g. possession of alcohol; disorderly conduct) from §6.0.

Third, the DOE proposes to delete the definition of “bullying” from the current regulation while still requiring reporting of “bullying” under §6.0. The Department may wish to include a definition in §2.0 which cross references the statutory definition [Title 14 Del.C. §4112D(a)]. Indeed, the latter statute requires reporting of “bullying” as defined in the statute [Title 14 Del.C. §4112D(b)(2)].

I recommend sharing the above observations with the DOE, SBE, and ACLU.

9. DDDS Proposed Eligibility Regulation [11 DE Reg. 423 (October 1, 2007)]

The SCPD, GACEC, and DDC previously commented on an earlier version of these proposed regulations published at 11 DE Reg. 18 (July 1, 2007). I attach a copy of the GACEC's July 25 letter for facilitated reference. DDDS has now issued a revised set of proposed standards. The revised version remains poorly drafted and substantively problematic.

I have the following observations and recommendations.

First, the preface to the regulation (at 423) and public notice (p. 523) recite that the Division will convene a public hearing to receive comments. However, no time or date of the public hearing are provided. This violates the APA which provides as follows:

The notice shall state the manner in which persons may present their views: (i) if in writing, of the place to which and the final date by which such views may be submitted; or (ii) if at a public hearing, the date, time and place of the hearing. If a public hearing is to be held, such public hearing shall not be scheduled less than 20 days following publication of notice of the proposal in the Register of Regulations.

Title 29 Del.C. §10115(a)(2). [emphasis supplied]

Second, in Section 1.0, DDDS should substitute “meet” for “meets” for ensure proper grammar.

Third, as noted in the Councils' July comments, the regulation is inconsistent in its use of the terms “disability” and “disorder”. The reference in the overriding standard (§1.0) is solely to “disability”. Likewise, §1.5 solely refers to disability. In contrast, §1.3 refers to both “disability/disorder” and §§ 1.3.3 and 2.0 solely refer to disorder. The term “disorder” is ostensibly a broader term than disability. For consistency, the Division should consider amending §1.0 to refer to “disability/disorder”, i.e., the same language used in §1.3.

Fourth, there is some “tension” between §1.1 and the recent decision in Duffy v. Meconi, No. 05-127 (D.Del. September 11, 2007). At a minimum, I recommend consideration of the following amendment:

...a resident of the State of Delaware; provided, however, that the Division may entertain, assess, and process an application from a non-resident who confirms the intent to establish Delaware residency; ...

Otherwise, the regulation would literally preclude the Division from providing the assessment services necessary to determine eligibility.

Fifth, as noted in the Councils' July comments, the word “generalized” should be deleted from §§1.3.1 and 1.3.5. The Councils' remarks remain apt:

References to “generalized limitation in intellectual functioning” are anachronisms. They were present in the 1983 AAMR definition. See AAMR, Mental Retardation: Definitions,

Classification, and Systems of Supports, 10th Edition (2002) at p. 22. The 2002 AAMR criteria affirmatively reject the notion that limitations must be “generalized”. Rather, they recite that “within an individual, limitations often coexist with strengths.” At pp. 8 and 23.

Sixth, as noted in the Councils’ July comments, the format of the regulation is awkward. For example, there is no punctuation whatsoever at the end of §1.1, 1.2, 1.3.4, 1.3.5, 1.4, and 1.5. It resembles a conceptual draft rather than a formal regulation.

Seventh, the new “grandfather” provision (§1.6) is problematic. For example, consider a current client who qualified under 1999 DMR criteria based on having functional limitations in both social skills and functional academics. The 1999 DMR standards required functional limitations in 2 adaptive skill areas:

“Mental retardation” refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care; home living; social skills, community use, self-direction; health and safety; functional academics; leisure; and work. Mental retardation manifests before age 18.

If that client no longer has functional limitations in functional academics, he would no longer meet the “requirements of the regulations under which the client initially established eligibility”. The Catch-22 is that the client is categorically precluded from invoking eligibility under the new regulation since, literally, “the requirements of 1.3 through 1.5 shall not apply to any client who is receiving services on the effective date of these regulations”.

The same Catch-22 would apply to a current DDDS client with Asperger’s Disorder. If DDDS has some clients with Asperger’s Disorder whose overall skills have improved somewhat with age, they may not meet the eligibility standards from years ago and they are categorically precluded under §1.6 from establishing eligibility under the new standards.

The Division should abandon this concept of subjecting all current clients to maintaining eligibility under standards which applied when initially determined eligible. Query whether the Division even has the criteria from the 1930s and 1940s to apply the regulation to older clients. There were Stockley Center residents and former Stockley Center residents admitted to DDDS-predecessor agency services under archaic and discredited “eligibility” criteria based on the Eugenics movement. Query whether current clients should be subjected to an assessment of whether they currently qualify as an idiot, imbecile, or moron?

Eighth, the Division has reinstated a limited authorization for persons with brain injury or neurological conditions related to mental retardation to qualify for DDDS services. Section 1.3.5 recites as follows:

Brain injury or neurological condition related to mental retardation that meets: a) a significant generalized impairment in intellectual functioning (defined in 1.3.1); b)

significant limitations in adaptive behavior functioning (defined in 1.4); and c) originates before age 22 (defined in 1.5).

A. At a minimum, the structure of this standard should be reassessed. Pars. b) and c) are completely redundant. Everyone qualifying for DDDS services must meet the standards in §§1.4 and 1.5. There is no reason to repeat the adaptive functioning and age-22 onset standards. Consistent with the “Sixth” comment above, DDDS should insert “; and” at the end of §1.3.5 to clarify the Division’s intent. This would result in the following:

1.3.5 Brain injury or neurological condition related to mental retardation which meets the criteria of intellectual functional limitation contained in §1.3; and

B. While the reinstatement of limited eligibility for persons with brain injury in §1.3.5 is welcome, it remains narrowly defined to only include persons with both intellectual functioning in the mental retardation range and adaptive functioning limitations. Since DDDS is not requiring low intellectual functioning for persons with Asperger’s Disorder, Autism, or Prader-Willi Syndrome, it is anomalous to impose the requirement on persons with brain injury. Consistent with the Councils’ earlier commentary , I therefore recommend the following substitute for the proposed §1.3.5:

1.3.5. Brain injury, including Dementia Due to Head Trauma (294.1)(American Psychiatric Association Diagnostic & Statistical Manual-IV, 1994); and/or

Applicants with brain injury would still have to meet the same adaptive behavior limitations applied to other conditions through §1.4.

If DDDS is disinclined to adopt this recommendation, I recommend consideration of the following compromise:

1.3.5. Brain injury characterized by limitation in intellectual functioning defined as IQ scores approximately one standard deviation below the mean.

Consistent with the attached I.Q. table, this would equate to an I.Q. of 85. Alternatively, DDDS could consider adopting a standard of 1.5 deviations below the mean which would equate to an I.Q. of approximately 77.5.

C. Substantively, the regulation is highly objectionable since it does not “capture” conditions “similar to Autism, Asperger’s Disorder, and Prader-Willi Syndrome”. See attached July 25, 2007 GACEC comments, at p. 4. There are both rare and common conditions which may be categorically excluded from DDDS eligibility by barring eligibility of persons with similarly impairing diagnoses. For example, individuals with hyperphagic short stature (HSS) have very similar profiles to individuals with Prader-Willi Syndrome. See attached comprehensive study. Insatiable eating (hyperphagia) is similar for both diagnoses. Children with HSS had a mean I.Q. of 77 while children with PWS had a mean I.Q. of 54 with the highest I.Q. being 90. If an application were filed with DDDS for an individual with Prader Willi Syndrome with an I.Q. between 70-90,

that individual would not be disqualified. The same individual with an HSS diagnosis would be categorically disqualified. This is not a “fair” or desirable result. Consistent with the Council’s prior commentary, the following could be substituted:

1.3.6. A neurological disability/disorder closely related to those listed in §§1.3.1 to 1.3.4; including Pervasive Developmental Disorder (American Psychiatric Association, Diagnostic & Statistical Manual-IV, 1994); if such disorder results in an impairment of intellectual functioning and/or adaptive behavior functioning similar to such disorders.

I recommend that the SCPD share the above observations and recommendations with DDDS and other affected groups (e.g. ARC; UCP; Autism Society; BIA; DCMHS).

10. DSAMH Prop. Substance Abuse Facility Licensing Regs. [11 DE Reg. 448 (October 1, 2007)]

The Division of Substance Abuse & Mental Health proposes to replace its existing licensing standards applicable to substance abuse facilities. The existing standards were adopted in 1979 with few changes since then. At 449.

I have the following observations.

First, it is unclear whether the regulations apply to children’s facilities. The licensing statutes [Title 16 Del.C. §§2206(1), 2207, and 2208] authorize DHSS to adopt standards, in consultation with the DSCY&F, for adult and children’s facilities. DHSS is also authorized to delegate to the DSCY&F the authority to issued regulations for children’s facilities. There is no recital in the regulations that DSCY&F has been consulted. Moreover, all the references in the lengthy regulation are to DSAMH to the exclusion of DSCY&F. I identified only three references [§5.1.4.4.1.14; §5.1.7.1.1.2; §7.1.2.1.7] which suggest coverage of children’s facilities since they require reporting of child abuse or neglect. DSAMH should clarify whether the standards apply to both adult and child facilities. If the standards do apply to children’s facilities, DSAMH should consider revisions to address children. For example, residential facilities and some day programs should ensure that minors receive schooling. Cf. Title 16 Del.C. §5161(a)(12)[residential mental health facilities must ensure education of minors].

Second, the definition of “counseling” in §3.0 only permits “face-to-face interaction” between counselor and clients, family members, and significant others. The regulations include some minimum amounts of such “counseling”. See, e.g., §§10.1.8, 11.1, and 12.1. Literally, the regulation may categorically preclude use of videoconferencing and teleconferencing. Such modalities may be necessary to promote participation by family members and significant others. The Division should consider authorization of such modalities at least under some circumstances (e.g. family is distant or lacks transportation). Moreover, the Division may wish to clarify whether videoconferencing amounts to “face-to-face interaction”.

Third, I was pleased to note that the definition of “medical history” in §3.0 affirmatively references “head injuries”. Given the “underidentification” of TBI, this merits endorsement.

Fourth, §4.5.2.1 requires compliance with the ADA in license applications. Likewise, §7.1.1.3 requires compliance with ADA standards. These provisions merit endorsement.

Fifth, in §4.13.4 there are some extraneous brackets “[]”.

Sixth, §4.15.4 invariably requires any waiver granted by the Division to extend for the full term of the existing license, i.e., up to 2 years. This unnecessarily limits the Division’s discretion. For example, there may be circumstances under which a short-term waiver would be more appropriate. DSAMH should consider adopting the approach reflected in DLTCRP regulations covering DDDS neighborhood homes, 16 DE Admin Code 3310, §17.4. Section 17.4 provides as follows: “A waiver may be granted for a period up to the term of the license.”

Seventh, at least in the context of residential facilities, it is preferable to require that notice of the waiver request be shared with residents to permit input from persons who may be most affected. Compare 16 DE Admin Code 3310, §17.1.4. No harm is done by promoting the opportunity for consumer input into waiver requests.

Eighth, §5.1.1.4 requires the facility’s Governing Body to meet only once annually. If DSAMH wishes to promote an active, knowledgeable board, this standard may fall short of achieving that objective.

Ninth, facilities are required to make mandated reports of child abuse [§§5.1.4.4.1.16; 5.1.7.1.1.2; and 7.1.2.1.7]. There is no comparable provision requiring reporting of abuse, mistreatment, neglect, or financial exploitation as required by Title 16 Del.C. §2224. This oversight should be corrected.

Tenth, there is an anomaly in §6.1. Section 6.1.2.1.1 requires the Clinical Director to have a “master’s degree in counseling or a related discipline.” Section 6.1.3.1.1. requires a Clinical Supervisor to have a bachelor’s degree with “a major in chemical dependency, psychology, social work, counseling, or nursing.” The “related discipline” standard applicable to the Clinical Director is ostensibly narrower than the educational background standards for the Clinical Supervisor (degree in chemical dependency, psychology, social work, counseling, or nursing). For example, could a Clinical Director qualify with a master’s degree in nursing? DSAMH may wish to clarify “related discipline” by at least providing some specific examples of acceptable contexts of degrees.

Eleventh, §7.1.1.1 is problematic. It recites as follows:

No program shall deny any person equal access to its facilities or services on the basis of race, color, religion, ancestry, sexual orientation, gender expression, national origin, or disability, unless such disability makes treatment offered by the program non-beneficial or hazardous.

[emphasis supplied] The underlined exclusion is an inane standard which is not consistent with

the ADA, §504, or the Equal Accommodations statute (Title 6 Del.C. Ch. 45). It is also inconsistent with §7.1.3.1. For example, it would authorize a program to deny services to a Deaf applicant since the Deaf applicant could not benefit from the existing program. Legally, the program must provide accommodations to ensure that its program is beneficial to the applicant with disabilities. In this example, the program should not be barring the Deaf client from admission. It should be providing a sign-language interpreter. Similarly, there is no “hazardous” exception in the ADA [28 C.F.R. §§35.149-35.150 (public entities); 28 C.F.R. §36.302(private entities)]. For example, it may be “hazardous” for a person with ambulatory limitations to climb a stairway to an upper floor location. However, rather than denying that person services, the provider should be providing accommodations (e.g. moving counseling session to ground floor). If a specialty program does not offer the type of treatment that a person with a disability seeks, the program is expected to make a referral to another program. See 28 C.F.R. §36.302(b). If an applicant poses a “direct threat” or “safety” risk to a private provider, that assessment must be made in the context of accommodations. [28 C.F.R. §§36.208 and 36.301].

Twelfth, §7.1.2.1.9 should be expanded to include a reference to advocates and advocacy agencies. See Title 16 Del.C. 2220(17).

Thirteenth, §7.1 would benefit from addition of a “catch-all” provision requiring compliance with Title 16 Del.C. §2220. This would be consistent with §8.1.2.1.2.11.1, which requires programs to provide notice of such rights to clients.

Fourteenth, §§8.1.2 and 8.1.3 could be strengthened in the context of discharge planning. Compare, in the mental health context, §5161(b)(4), which contemplates that the discharge plan be developed in consultation with anticipated post-discharge providers. See also DLTCRP mental health group home regulations, 16 DE Admin Code 3305, §6.8.

Fifteenth, requiring facilities to only maintain records for 12 months [§8.1.4] is too short. Contrast the DLTCRP mental health group home regulations [16 DE Admin Code 3305, §8.1] which require that records be maintained for 7 years!

Sixteenth, there is an extraneous reference to §8.1.2.2 in the margin next to §10.1.6.

Seventeenth, §12.4.2.2.1 authorizes restrictions on phone use. Such restrictions may be precluded by Title 16 Del.C. §2220(11).

Eighteenth, §14.1.1.1.6 categorically precludes admission to opioid treatment services unless the applicant has been addicted at least 1 year. This categorical exclusion may unnecessarily limit provider clinical judgment and discretion.

Nineteenth, the rationale for precluding admission to opioid treatment services by someone released from a penal institution within 6 months [§14.2.1] may also unduly restrict provider discretion. For example, the applicant could have been in a penal institution (e.g. pre-trial pending release on bail) for only a few days.

Twentieth, in §14.7, it would be preferable to include a provision requiring that the applicant be provided with the specific reasons for denial of admission. Indeed, public entities would be required to provide such information as a matter of due process.

Twenty-first, §14.18.3 categorically bars admission of a client for more than 2 detoxification treatment episodes in 1 year. It is unclear why such a restriction would be included in a licensing standard. If an applicant wishes to “private pay” for detoxification, or an insurer will cover such costs, why should the State categorically preclude access to detoxification? If DSAMH wishes to impose such a standard for detoxification paid for by the State, it could do so by contract. Otherwise, providers should be allowed to exercise professional discretion.

I recommend that the above observations be shared with DSAMH with a copy to NAMI, the Governor’s Advisory Council to DSAMH, and the DCMHS.

11. DMMA Prop. ABI Medicaid Waiver [11 DE Reg. 442 (October 1, 2007)]

The Division of Medicaid & Medical Assistance submitted a waiver application to CMS on August 31, 2007 covering persons with acquired brain injury (“ABI”). DMMA has now published a request for public input.

I have the following observations.

First, the SCPD has been very involved in development of an ABI waiver. In the past, DHSS had secured CMS approval of an ABI waiver which it later abandoned based on an inability to secure providers. DHSS then attempted to have existing waivers amended to address the specific needs of persons with ABI. This initiative was abandoned in the Spring based on CMS lack of receptivity. Since then DHSS has worked on development of a new ABI waiver. The SCPD has offered technical assistance to support renewed development of the waiver which will be effective December 1, 2007.

Second, the overall program is “provider-based” and adopts a commercial-provider services model. Unlike the attendant services program, participant direction of services is not an option. [Application:5; Appendix E-1:1] Since the services are more varied than attendant services, there may be some justification for adopting this approach in the initial 3-year waiver period.

Third, some positive aspects of the waiver include consumer choice of providers [Application: 8; Appendix B-7:1] and an individual service plan which covers wrap-around services, not simply those under the waiver program [Application: 7; Appendix D-1:4].

Fourth, there is an MOU between DSAAPD and DMMA, signed in July of 2007, which describes agency collaboration in implementing the waiver. [Appendix A:1; Appendix H:3]. The Council may wish to solicit a copy.

Fifth, the quality assurance system is relatively strong in the context of number of cases reviewed. A DSAAPD nurse will review 100% of initial case plans. [Appendix A:4; Appendix D-1:7]. DMMA will conduct retrospective review of 25% of ABI care plans. [Appendix A:2; Appendix D-1:7]. The latter review will be a “desk audit to ensure completion in accordance with all applicable ABI policies and procedures.” Nurses will meet participants and review records of participants in AL facilities 3-4 times/year. [Appendix G-3:2] The weakness with this system is its lack of consumer surveys akin to the attendant services program. Reviewing paperwork will not result in identification of some deficiencies and diminishes the importance of consumer views of the responsiveness of the program to their needs.

Sixth, although there is a minimum age limit (age 18), there is no maximum age limit. [Appendix B-1:1. This merits endorsement, especially since many of the individuals in the E&D waiver will be elderly.

Seventh, there is a problematic statement at Appendix B-1:2. DMMA recites as follows:

The ABI Care Plan for participants in the waiver must demonstrate that the ABI waiver participant would benefit from ABI case management and at least one other ABI waiver services...that are not available in another waiver.

[emphasis supplied]. This may be an unnecessary restriction. It means that a person living outside an assisted living setting who seeks only personal care, respite, and a personal emergency response system would not qualify for the ABI waiver.

Eighth, apart from the requirement that a waiver participant meet a nursing level of care [Application: 2; Appendix B-6:2], DMMA imposes a severity test. A participant must “have a rating of at least 5 but not greater than 8 on the Rancho Los Amigos Level of Cognitive Functioning Scale. I attach a copy of the Scale. One could argue that a person at Level IX could still benefit from waiver services. The Council may wish to obtain input from professionals in this context.

Ninth, an aggregate rather than an individual cost cap is used in this waiver. [Appendix B-2:1; Appendix C-4:1]. This merits endorsement.

Tenth, in the first year, up to 50 individuals may participate in the waiver. This would increase to 60 individuals in Year 2 and to 70 individuals in Year 3. [Appendix B-3:1] There is no prioritization based on current institutionalization, applicants in crisis, or geographical location. [Appendix B-3:2] If the waiver reaches capacity (50 persons in Year 1), a waiting list would be developed. First priority for the waiting list would be given to E&D and AL waiver participants. Second priority for the waiting list would be given to non-participants in the E&D and AL waivers. There is obviously a “cost” aspect to this prioritization since the State will spend less by transferring persons in an existing waiver to a new waiver. However, the Council may wish to consider whether some variation of this prioritization would be preferable. For example, if an individual with TBI is homeless and “in crisis”, it may make sense to prioritize such an individual over someone receiving supports under an existing waiver.

Eleventh, financial eligibility is limited to individuals with countable income under 250% of the federal benefit rate (FBR). [Appendix B-4:2] Consistent with the attachment, the FBR for an individual in 2007 is \$623 and 250% of the FBR would be \$1,557.50. The Council may wish to suggest that DMMA adopt a 300% of FBR standard which would equate to \$1,869/month in countable income.

Twelfth, DMMA requires a participant to require at least 1 waiver service apart from case management on a monthly basis. DMMA did not adopt the option of “monthly monitoring of the individual when services are furnished on a less than monthly basis”. The problem with this approach has been debated in the context of the DD waiver. Under that waiver, individuals who are very elderly (80), recovering post-hospitalization, or diagnosed with cancer with 4 months to live still must attend a day program or lose waiver eligibility. If an ABI waiver participant cannot attend Enhanced Level II day services or day habilitation due to illness or other cause, DMMA unnecessarily restricts its discretion to maintain the person’s waiver eligibility.

Thirteenth, the menu of services is as follows: 1) case management; 2) personal care; 3) adult day health; 4) day habilitation; 5) respite; 6) day treatment (cognitive treatment); 7) personal emergency response system; and 8) assisted living. [Appendix C-1:1] The scope of some of these services is not intuitive. For example, the waiver does not cover room and board for assisted living. [Appendix C-2:3] Rather, it covers only the cost (approximately \$37.17 to 64.76 daily) of some enhanced services. [Appendix I-2:1; Appendix J-2:2; Appendix J-2:7] As a practical matter, this may exclude participation in the waiver by many assisted living residents. Query how many individuals will be financially able to pay approximately \$36,000 for assisted living base costs when they can only have countable income of 250% of the FBL (\$1,557.50)? Moreover, many AL facilities already provide the contemplated enhanced services, including “prompting”. [Appendix C-3:3]. See, e.g., attached rate levels for sample AL facility (Somerset). Forty percent (40%) of waiver participants are expected to receive AL services. [Appendix J-2: 2] DMMA suggests that State funds might be used for room and board but it is unclear if such funds are included in the DHSS budget. [Appendix I-5:1]

Fourteenth, DMMA had the option of allowing relatives to provide waiver services. However, it did not exercise this option for any service. [Appendix C-2:4; Appendix C-3:3; Appendix C-3:7; Appendix C-3: 11; Appendix C-3:13; and Appendix C-3:15]. This is objectionable. At least in the contexts of respite and personal care services, relatives should be authorized providers. Compare attached DDDS respite policy, which recites as follows:

O. Natural families may identify a family member or other individual (at least 18 years of age) whom they feel is appropriate to provide private respite for their family member. It shall be the responsibility of the family to insure that the said private provider is competent to provide adequate support to ensure the individual’s health and safety.

Moreover, DHSS recently amended its attendant services program policy to authorize payment of relatives. See attached email which resulted in policy change during summer.

Fifteenth, case management can only be provided by an RN or LCSW. [Appendix C-3:1] This should enhance the quality of services plans. Many organizations use case managers with only a bachelor's degree.

Sixteenth, the waiver includes utilization limits. Some of these limits are odd. For example, the limit for both adult day services and day habilitation is 4 days per week. [Appendix C-3:5; Appendix C-3:7] It is inferable that most individuals attending day programs attend 5 days/week. Exceptions are allowed based on case manager requests. *Id.* In this sense the limits are akin to the "Code" in the Pirates of the Carribean film, i.e., they are more akin to "guidelines". However, it would make sense to establish a guideline of participation in day services and day habilitation of 5 days/week. In the context of "cognitive services" [Appendix C-3:9], DMMA may similarly wish to upgrade the 20 visits/year limit. This equates to only 1.66 counseling visits per month. Other questionable limits apply to personal care services (14 hours/week)[Appendix C-3:11]; and respite (80 hours/year)[Appendix C-3:13]. Parenthetically, the limits may have been set somewhat low to reduce projected costs.

Seventeenth, DMMA recites that the aggregate cost cap is based on "both waiver services and other services." [Appendix C-4:1]. This may not be 100% accurate. Services which are "private pay" or derived from non-Medicaid sources should not be include in the aggregate cap. The expected per participant cost in Year 1 is expected to be \$6,901. [Appendix C-4:2]

Eighteenth, DMMA limits case management to agencies which do not provide services under the individual client plan. [Appendix D-1:1] This reduces the prospects for conflicts of interest in which the case manager "loads up" the plan with its own services. On the other hand, it limits the potential role of a TBI specialty provider which could otherwise offer both an LCSW case manager and counselor.

Nineteenth, the ABI care plan must include back-up plans in the event the regular provider becomes unavailable. [Appendix D-1:6]. This merits endorsement.

Twentieth, case managers must meet "in-person" with participants at least monthly. [Appendix D-2:1; Appendix D-2:2] This merits endorsement.

Twenty-first, DSAAPD will refer persons who request a fair hearing to the Community Legal Aid Society, Inc. for assistance. [Appendix F=1:1] This merits endorsement.

Twenty-second, the use of seclusion or restraint is expressly prohibited. [Appendix G-2:1] This merits endorsement.

Twenty-third, DMMA incorrectly recites that administration of medication is limited to medical personnel or personnel who have completed Board of Nursing training. [Appendix G-3:3]. This ignores a participant's right to self-administer medications; the participant's right to delegate administration to others consistent with Title 24 Del.C. §1921(a)19); and the right of relatives, friends, housekeepers, and servants to administer medications consistent with Title 24 Del.C. §1921(a)(4). *See also* Title 24 Del.C. §1921(a)(18)[Nurse Practice Act not applicable to attendants acting pursuant to Attendant Services Act].

Twenty-fourth, estimated costs of the waiver services are compiled at Appendix I-2 and Appendix J-2. Reimbursement rates for some services are actually somewhat high, i.e., respite is \$26.68/hour and personal care is 30.32/hour. This may be a function of the commercial provider bias inherent in the waiver. Note that rate increases may be deferred if State appropriations are insufficient. [Appendix I-2:1]

Twenty-fifth, DMMA recites that the “State does not make supplemental or enhanced payments for waiver services.” [Appendix I-3:2] This appears inconsistent with references to payments for supplemental services or additional reimbursement throughout the application. [Appendix C-3:3; Appendix C-3:5]

Finally, the Division anticipates negligible turnover in waiver participants. This is ostensibly a realistic prediction. [Appendix J-2: 1]

I recommend sharing the above observations and recommendations with DMMA and DSAAPD with a copy to SCPD BIC members and the BIA.

ADDENDUM

The following memo was submitted to the SCPD in September since a vote on the NCC ordinance was expected prior to the SCPD’s P&L Committee meeting on October 11. The SCPD issued a conforming letter.

MEMORANDUM

To: SCPD P&L Committee

From: Brian Hartman

Re: NCC Property Tax Abatement Ordinance [07-131]

Date: September 28, 2007

I am providing my preliminary analysis of the above ordinance on an expedited basis since a NCC Council vote is expected on October 9 and the next P&L Committee meeting is scheduled on October 11. I recommend that comments be submitted well in advance of the October 9 County Council meeting since I am recommending some amendments.

In September, the SCPD and other organizations submitted comments on a predecessor ordinance intended to reduce property tax and sewer exemptions for senior citizens and persons with disabilities. Consistent with the attached September 12 News Journal article, that ordinance [07-114] was withdrawn after a groundswell of communication from the public. The new ordinance [07-131] was introduced on September 25 in anticipation of a vote on October 9. For background, I am attaching a copy of the ordinance, September 25 press release, September 24 News Journal article, and September 25 News Journal article.

The new ordinance does reflect the SCPD’s influence. The attached September 24, 2007 News Journal article recites as follows:

In a nod to a request from the State Council for Persons with Disabilities, Smiley is offering to raise the income limit for disabled homeowners to \$50,000 so they can have parity with seniors.

To facilitate review, I am providing the following tables which highlight the most significant changes between existing law and the proposed ordinance.

The current ordinance reflects the following standards:

	Residency Duration	Income Cap (excludes Social Security & RR Retirement)	Property Tax Assessed Value Exemption	Cap on “Expensive” Real Property
Elderly	Resident as of July 1 of Fiscal Year	\$50,000 individual \$50,000 couple	\$50,000	None
Persons with Disability	Resident as of July 1 of Fiscal Year	\$40,000 individual \$40,000 couple	\$40,000	None

Under the new ordinance, persons currently qualifying for the above exemptions would be unaffected, i.e. grandfathered. Indeed, even if a “grandfathered” taxpayer moved to a new house, the old exemption limits would apply to the new house. For new applicants, the following standards would apply:

	Residency Duration	Income Cap (excludes Social Security & RR Retirement)	Property Tax Assessed Value Exemption	Cap on “Expensive” Real Property
Elderly	4 years	\$50,000 individual \$50,000 couple	\$32,000	\$125,000 Assessment (equates to \$400,000 market value per article)

Persons with Disability	4 years	\$50,000 individual \$50,000 couple	\$32,000	\$125,000 Assessment (equates to \$400,000 market value per article)
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Sewer bills would also be affected. According to an August 7 News Journal article, persons qualifying for an exemption currently pay a flat sewer fee of \$36.00 annually. This is based on a fee adopted by County Council. This approach would be continued for “grandfathered” taxpayers. For new applicants, the elderly and persons with disabilities would be billed 50% of total sewer charges or a minimum bill set by Council, whichever is greater. See Ordinance 07-114, Section 3, Par. G.

I have the following observations to share if County Council intends to pursue enactment of this ordinance.

First, the “grandfather” provision merits endorsement. The elderly and persons with disabilities are often on fixed incomes who have grown to reasonably rely on the current exemptions.

Second, the new ordinance restores equity by adopting the same standards for the elderly and persons with disabilities. This equity had been displaced by a 2004 ordinance. This restoration merits endorsement.

Third, the ordinance does result in an anomaly. “Grandfathered” taxpayers with disabilities would still be subject to the \$40,000 income cap. New applicants with disabilities would only be subject to a \$50,000 income cap. Thus, if a “grandfathered” individual or couple’s countable income increased from \$39,000 to \$41,000 on or after tax year 2008, the “grandfather” exemption would be lost. It would be preferable to amend the ordinance to raise the income cap to \$50,000 for “grandfathered” persons with disabilities.

Fourth, Section 1, Proposed Section 14.06.303B2, incorporates an existing supplemental exemption for certain taxpayers who have lost limbs. Disability must be “due to the loss or loss of the use of both lower extremities or both upper extremities or both an upper and lower extremity such as to preclude locomotion without the aid of a brace, crutch, cane, or wheelchair and such as to require a home with special fixtures.” While the concept underlying this supplemental exemption is salutary, the actual language could be improved. For example, it would literally not cover someone who was born without use of limbs since there has been no “loss”. Moreover, it would literally not cover someone using a “walker”, scooter, or other mobility device. I recommend the following substitute:

...(D)ue to the loss or inability to use both lower extremities or both upper extremities or both an upper or lower extremity such as to significantly impair locomotion without the aid of a brace, crutch, cane, wheelchair, or other assistive technology and such as to require a home with special fixtures.

Parenthetically, the term “assistive technology” is well known and defined in law. It would encompass walkers, scooters, etc. Compare 29 U.S.C. 3002(a); 20 U.S.C. 1401(1); and Title 16 Del.C. Sec. 9403(3)b.

I recommend that the SCPD consider sharing the above observations and recommendations with policymakers.

Attachments

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