

MEMORANDUM

To: SCPD Policy & Law Committee  
From: Brian Hartman  
Re: Legislative and Regulatory Initiatives  
Date: May 5, 2008

I am providing my analysis of seventeen (17) legislative and regulatory initiatives in anticipation of the May 8 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. DSS Final Child Care Subsidy Regulations [11 DE Reg. 1488 (May 1, 2008)]

The SCPD commented on the proposed version of these regulations in March, 2008. The Council shared an analysis of the standards and did not identify any concerns.

The Division of Social Services has now thanked the Council for its observations and adopted the standards as final regulations. No further action is warranted.

2. DSS Final Fair Hearing Regulations [11 DE Reg. 1482 (May 1, 2008)]

The SCPD and GACEC commented on the proposed version of these regulations in March, 2008. The Division of Social Services has now adopted final regulations with several amendments prompted by the Councils.

First, the Councils recommended changing the reference to “MCOs” to encompass the DCMHS. DSS agreed and effected an amendment.

Second, the Councils recommended expanding the scope of jurisdiction beyond “financial assistance” to include “economic, medical, vocational or child subsidy assistance.” DSS agreed and adopted the suggested amendment verbatim.

Third, the Councils recommended adding other covered divisions subject to the fair hearing system in connection with Medicaid and other benefits, including DDDS and DSAAPD. DSS agreed and also added the Division of Public Health which is involved with the AIDS waiver.

Fourth, the Councils recommended adding the DLTCRP and clarifying that appeals of

nursing home discharges are subject to the fair hearing regulations. The Councils noted that the DLTCRP currently processes discharge hearings with no regulations whatsoever. DSS notes that it, not the DLTCRP, may have jurisdiction over nursing home discharge hearings and that “this jurisdictional issue is under review by DHSS’s legal council (sic ‘counsel’).” This is an important issue and the SCPD may wish to follow up in a few months.

Fifth, the Councils objected to a prohibition on hearing officer assistance to “either party in the presentation of the case”. DSS retained the prohibition.

Sixth, the Councils objected to changes in the burden of proof and persuasion and removal of hearing officer discretion in this context. DSS made no change.

Seventh, the Councils recommended amendments clarifying that the consumer has the burden of proof only for “initial” ineligibility determinations and denials. DSS agreed and inserted the amendment.

Eighth, the Councils recommended an amendment in the context of presentation of rebuttal evidence. DSS adopted an amendment to clarify the standard.

Since the regulations are final, and DSS adopted several amendments prompted by the Councils, I recommend no further action apart from follow-up in a few months on the issue of jurisdiction over nursing home discharge hearing requests.

### 3. DMMA Final Medicaid Vehicle Resource Regulations [11 DE Reg. 1479 (May 1, 2008)]

The SCPD and GACEC commented on the proposed version of these regulations in March, 2008. The Councils shared three (3) recommended amendments. The Division of Medicaid and Medical Assistance has now adopted final regulations incorporating all recommended amendments as follows: 1) grammatical edits were adopted; 2) the status of a vehicle as a “non-liquid” resource was clarified; and 3) the equity value of a vehicle was modified to the price it could reasonably sell for on the open market “in Delaware”.

Since DMMA adopted all recommended edits, the Councils may wish to send a “thank you” letter.

### 4. DMMA Final School Based Wellness Center Funding Regs. [11 DE Reg. 1477 (May 1, 2008)]

The SCPD and GACEC commented on the proposed version of these regulations in March, 2008. The Councils noted that CMS was prompting the Division to adopt a funding standard for school based wellness centers. The Councils observed that DMMA was proposing no change in services and adopting a reimbursement system based on a single rate for each client served in a center based on prior year center costs. The Councils had no objection to the proposed amendments.

The Division has now acknowledged the Councils’ observations and adopted final regulations. However, DMMA amended one sentence and added three (3) sentences which were

not included in the proposed regulations. Under the Administrative Procedures Act, DMMA can adopt the revised standards if the “agency head” determines that the changes are “nonsubstantive”. See Title 29 Del.C. §10118(c). Assuming this determination was made, there is a minor grammatical error, i.e., the word “or” was omitted from the amended sentence which now reads: “The single rate is based cost reports for the prior year submitted in a format specified by the Medicaid agency.” At a minimum, DMMA may wish to correct the oversight through an erratum. If it does so, DMMA may also wish to consider deletion of the superfluous comma between “and” and “(2)” in the final sentence.

5. DOE Final Tobacco Policy Regulations [11 DE Reg. 1463 (May 1, 2008)]

The SCPD and GACEC commented on the proposed version of these regulations in March, 2008. The Councils noted that the proposed regulation simply required public schools to submit an electronic version of their tobacco policies and any prospective amendments to the Department of Education. The Councils endorsed the proposed standards.

The Department has now acknowledged receipt of the Councils’ comments and adopted final regulations with no changes. No further action is required.

6. DMV Proposed Use of Translators Regulations [11 DE Reg. 1460 (May 1, 2008)]

The Division of Motor Vehicles proposes standards for use of translators in the context of driver license written and road tests. I have the following observations.

First, the regulations literally apply to “driver license applicants who cannot read or speak English.” [§2.0]. This would encompass many Deaf individuals who communicate with ASL or signed English. As applied to the Deaf, the standards would ostensibly violate Title II of the Americans with Disabilities Act in multiple respects.

A. Section 5.3 requires a translator to “sit in the rear of the vehicle and relay instructions to the applicant...”. Query how a Deaf driver could observe signing from someone sitting in the back seat.

B. Sections 5.0 and 7.0 contemplate that the applicant must provide any interpreter at the applicant’s expense. There is no authorization for the DMV to provide a Deaf interpreter. Consistent with the attached excerpt [§II-7.1000] from the Title II Technical Assistance Manual, public entities must ensure effective communication. Interpreters must generally be provided if communication is lengthy or complex. In the context of the road test, which requires the applicant to follow discrete instructions from the DMV representative while driving a vehicle in traffic, an interpreter should be offered. Consistent with the attached excerpt [§II-3.5400] from the Title II Technical Assistance Manual, no surcharge for the interpreter is allowed. This is comparable to the prohibition on a surcharge for a special license plate for persons with disabilities under Title 21 Del.C. §2134(d). State motor vehicle offices in surrounding states uniformly offer interpreters for the Deaf at no charge. See, e.g., attached materials from Pennsylvania, New Jersey, Maryland, and Virginia. Parenthetically, since the Delaware DMV allows non-Deaf applicants to supply their own

interpreters, Deaf applicants must also be offered this option to avoid discrimination. Deaf applicants cannot be “required” to provide their own interpreters and the Delaware DMV must offer Deaf interpreter services.

Second, federal Title VI standards applicable to persons with limited English proficiency (LEP) are ostensibly less prescriptive than ADA standards. Consistent with the attached LEP “FAQs” overview, state agencies receiving federal funds must consider four (4) factors in determining “reasonable steps to ensure meaningful access to their programs and activities by LEP persons.” The four (4) factors are as follows:

1. the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee;
2. the frequency with which LEP individuals come in contact with the program;
3. the nature and importance of the program, activity, or service provided by the program to people’s lives; and
4. the resources available to the grantee/recipient or agency, and costs.

For some “high incidence” populations (e.g. Hispanic), it may be difficult to justify a rigid approach in which all applicants must bring their own interpreter at their own expense. The attached New Jersey Motor Vehicle Commission materials describe the availability of oral and written knowledge tests in a variety of languages. It would not be unduly burdensome for the Delaware DMV to at least develop tests based on Spanish. Consistent with the attached August 9, 2007 News Journal article, Hispanics account for 6.3% of the Delaware population.

Third, the DMV may also wish to compare its interpreter approach to that of other Delaware State agencies. For example, the attached DSS policy indicates that it pays for translation services in connection with all applications.

Finally, the regulations permit anyone to serve as an interpreter and excessive “prompting” may be discouraged through use of video and audio monitoring (§9.0). There are pros and cons to this approach. On the positive side, an individual will probably bring an interpreter who speaks the same dialect and is familiar with the applicant’s vocabulary and level of cognitive functioning. On the negative side, the prospect of interpreter prompting has led other states to restrict the pool of authorized interpreters. See attached materials. Weighing the options, I would favor a liberal approach to interpreter qualifications. The New Jersey approach of only allowing religious ministers, college faculty, and federal State Department certified interpreters to translate appears unduly burdensome and restrictive.

I recommend that the above observations be shared with the Division. The Council may also wish to share a courtesy copy of its comments with CODE and the Governor’s Consortium on Hispanic Issues established by Executive Order 89 issued on August 17, 2006.

#### 7. DMMA Proposed Third Party Data Exchange Regulations [11 DE Reg. 1417 (May 1, 2008)]

As background, the Deficit Reduction Act (DRA) of 2005 requires states to have laws to

facilitate Medicaid's role as the payor of last resort. Such laws must include provisions mandating that health insurers and other legally responsible parties provide the State with information to enable the State to determine the existence of third party coverage for Medicaid recipients.

In February, 2008, the Governor signed H.B. No. 101 into law. That legislation authorizes DHSS to require health insurers to provide specific information on Medicaid recipients. The information is characterized as "Plan Eligibility Data Elements". The Department can require insurers to provide data electronically in a format specified by DHSS at least every two (2) months.

The Division of Medicaid and Medical Assistance is now issuing proposed Medicaid Plan amendments certifying compliance with the DRA. I did not identify any concerns with the technical amendment which essentially confirms the adoption of H.B. No. 101.

I recommend sharing the above observations with DMMA and noting that the Council identified no concerns with the proposed standards.

#### 8. DMMA Prop. School-Based Transportation Regulations [11 DE Reg. 1420 (May 1, 2008)]

The Division of Medicaid and Medical Assistance proposes to amend its State Plan provisions related to school-based health services to narrow eligibility for transportation reimbursement.

As background, CMS issued proposed regulations last year [72 Fed. Reg. 51397 (September 7, 2007)] narrowing eligibility for Medicaid reimbursement of school transportation of students with disabilities between home and school and back. The regulations generated a groundswell of negative comments but were adopted as final standards at the end of 2007 [72 Fed. Reg. 73635 (December 28, 2007)]. Congress delayed implementation of the regulations through Section 206 of P.L. 110-173 until June 30, 2008. As a prophylactic measure, DMMA is now issuing regulatory amendments to become effective July 1, 2008 to comport with the CMS regulations.

I have the following observations.

First, there are multiple references in the Plan [§4.b.2) on p. 1423 and §5(d) on pp. 1424-1425] which refer to DOE and LEA eligibility for reimbursement. DMMA may wish to consider whether these references are "underinclusive". For example, charter schools are also public schools [Title 14 Del.C. §§501 and 503] which could logically benefit from participation in the Medicaid cost reimbursement program. Likewise, students placed by the DOE and districts in specialized private schools pursuant to Title 14 Del.C. §3124 would have IEPs. It is unclear if school-based health services of such students are recovered by the DOE and districts or if it would be beneficial to allow the private school to seek reimbursement.

Second, the prohibition on recovery of transportation services only applies to "school-age children". See 72 Fed. Reg. at 51403 and 72 Fed. Reg. at 73645 and 73648. CMS indicates that "(w)e do intend the term 'school-age children' to be defined by age." At 73648. DMMA can lessen the adverse impact of the CMS regulation by adopting a restrictive definition of "school-age

children”. Options include age 3 [based on Title 14 Del.C. §3101(5) and 16 DE Admin Code 900, §1.0]; or age 5 [based on Title 14 Del.C. §202 and 2721]. I recommend that DMMA affirmatively incorporate the age 5 standard in its Plan. For clarity, it would also be useful to indicate that students with IFSPs are still eligible for transportation reimbursement. Students with IFSPs are always under 36 months of age. See Title 16 Del.C. §§212 and 215.

Third, there are some hospital-based school sites that should arguably continue to be eligible for transportation reimbursement (e.g. the First State School and A.I. duPont school program). Although somewhat cryptic, CMS appears somewhat less rigid in the context of transportation to medical sites. In response to an inquiry about schools sending children to alternative placements because of a student’s medical needs, CMS responded as follows::

We agree, however, that when an individual is transported for the provision of medical services to a location that is not a school, such as a community provider, the transportation would be covered because that transportation was necessary to access a medical service not available in a school.

At 73646.

Fourth, CMS emphasizes that the limitation on transportation reimbursement does not affect eligibility for “medical services that might be required under an IEP or IFSP in the course of such transportation”, including “a personal care attendant or home health aide during transportation from home to school and back.” At 73642. See also commentary at 73645 (authorizing “monitoring or medical related services during transport” and commentary at 73646 (coverage continues for “medical equipment, appliances and supplies that are covered under the home health benefit”). DMMA may wish to include some clarifying provision or note in the State Plan to highlight the continued eligibility of such services. For example, on p. 1425 DMMA could add the following concluding sentence: “FFP for medical equipment, appliances, supplies, monitoring of related services, and home health services during transportation remain available.” The same sentence could also be included after “date.” in §4.b.(d) on p. 1423.

Fifth, there is “typo” at the top of p. 1423. The heading refers to “Remdial” which should be “Remedial”.

Sixth, p. 1423 contains the following standard:

With the exception of EPSDT screens, all services provided under this section are diagnostic or active treatments designed to reasonably improve the student’s physical or mental condition and are provided to the student whose condition or function can be expected to reasonably improve with interventions.

This statement essentially requires that services are limited to those linked to “medical improvement”. This is inaccurate. Under EPSDT, children are entitled to “health care, diagnostic services, treatment, or other measures ...to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services...”. See 42 U.S.C. 1396d(r)(5). This

has historically been interpreted to include maintenance of function or prevention of worsening of conditions:

EPSDT covers “necessary” diagnostic and treatment services to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screen. This definition of necessary EPSDT services is obviously broad. Thus, services must be covered if they correct, compensate for, or improve a condition, or prevent a condition from worsening - even if the condition cannot be prevented or cured.

NHeLP, “An Advocate’s Medicaid EPSDT Reference Manual” (1993) at p. 6 [excerpt attached].

This concept is reflected in the attached DMMA “medical necessity” regulation which is not limited to services causing medical improvement but include those which “prevent the worsening of conditions or effects of conditions” and services which allow a beneficiary to “retain” independence, self-care, etc.. A strict “medical improvement” standard would disallow all palliative services for a terminally ill child, palliative services to a non-terminally ill child experiencing pain, and all therapies and interventions for children with chronic health conditions which may never “improve” but whose functioning can be “maintained” or “prevented from worsening”.

Based on the above standards, DMMA should consider the following substitute standard:

All services provided under this section are diagnostic or active treatments designed to reasonably ameliorate, improve, or prevent the worsening of a mental or physical illness or condition.

I recommend that the Council share the above observations with DMMA. The commentary should also be promptly shared with DDDS since its constituents have chronic conditions who would be most harmed by adoption of a narrow “medical improvement” standard.

#### 9. DOE Proposed Unsafe School Choice Option Regulations [11 DE Reg. 1404 (May 1, 2008)]

The Department of Education proposes to adopt some discrete amendments to the existing regulations covering the unsafe school option.

As background, the No Child Left Behind Act requires the DOE to have a policy to allow students who are either victims of a violent felony in school or in a “persistently dangerous school” to “choice” to a safe school in the district, including a charter school.

The proposed amendments to the current standards are relatively benign. First, under §2.0, the DOE will consider expulsion and suspension data in identifying schools as persistently dangerous. Second, districts and charter schools will be required to submit an electronic version of its policies and procedures for implementing the choice option, including its process for notification to parents, to the DOE.

I did not identify any concerns with the above changes and I recommend endorsement.

10. DOE Prop. Student Teacher Crim. Background Check Regs. [11 DE Reg. 1407 (May 1, 2008)]

The SCPD and GACEC commented on prior versions of these proposed regulations in December, 2007 and February, 2008. DOE has now issued another set of proposed regulations.

I have the following observations.

First, the latest version of the regulations does include amendments prompted by the Councils' February commentary. The GACEC's commentary is attached for facilitated reference. Section 6.0 now includes a time period for retention of records by institutions of higher education. Moreover, Section 3.1.5 now includes an authorization for institutions of higher education to provide an appeal process to student teaching candidates.

Second, Section 3.1.5 is problematic in the context of appeals.

A. The determination that a candidate is suitable for a student teaching position is made by the higher education institution in conjunction with the public school [§§3.1.5 and 5.3]. The "final" determination is made by the public school [§5.3]. There is some ambiguity in this context since this "final determination" provision only appears in §5.3 and is absent from §3.1.5. Rather than a "final determination" approach, which could be construed as precluding a binding denial by a higher education institution, I recommend that DOE adopt a standard in which both the public school and institution of higher education must approve the placement.

B. The new regulation [§3.1.5] "allows" an institution of higher education to provide an appeal process and categorically precludes any applicant appeal of a public school denial. This categorical denial of a right to appeal ostensibly violates State statute. Title 11 Del.C. §8570 specifically includes "substitute teachers" within the class of "person seeking employment with a public school" subject to criminal background checks. Title 11 Del.C. §8571(h) directs the DOE to adopt implementing regulations which "shall include..establishment of a procedure for reconsideration of a determination to deny employment based on a person's criminal history." The DOE has no discretion in this context. It must provide a procedure for reconsideration or appeal to all persons covered by the statute. Parenthetically, the DOE's authority to "exempt" a school district decision from review is also limited by Title 14 Del.C. §1058. That statute allows any person aggrieved by a district decision involving its rules and regulations to appeal to the State Board. The State Board is authorized to establish hearing procedures but is not authorized to exempt controversies from Board review.

Third, Section 3.1.5.1 is grammatically infirm and may have omitted some language. It recites as follows:

Notwithstanding the above, a school district or charter school may have criteria for student teaching placement that differs from the criteria for public school employment, therefore a person in a student teaching position may be denied subsequently employment.

I recommend that the above observations be shared with the Department.

11. H.B. No. 379 and H.B. No. 387 [Hearing Aid Loan Bank]

H.B. No. 379 was introduced on April 23, 2008. H.B. No. 387 was introduced on April 24. The bills are identical. My comments are therefore applicable to both bills, one of which will probably be stricken at a later date. As of May 5, 2008, both bills remained in the House Health and Human Development Committee.

The synopsis of H.B. No. 387 bill recites that there were only two requests for hearing aids through the program in 2007, one of which was denied due to the age of the applicant, an 11 year old child. Given the underutilization of the program, the bill is designed to have two (2) effects.

First, the bill would expand eligibility by changing the current age cap from under age 3 to under age 18.

Second, the current law limits loans of hearing aids to a 6 month period subject to a 3 month extension. The bill would expand the authorized 3 month extension to a 6 month extension.

I have the following observations and recommendations.

First, there is a citation error in the bill. The reference to “§2605(6)” in line 3 should be to “§2605A(b)”.

Second, the sponsors may wish to consider other extensions of the loan period (e.g. 12 months with possible 6 month extension). This may make the program more attractive to prospective applicants.

I recommend sharing the above observations with policymakers.

12. H.J.R. No. 19 [Study of Maximum 15 Student Class Size]

This resolution was introduced on April 24 and remained in the House Education Committee as of May 5, 2008.

As background, Delaware law currently establishes a cap of 22 students per classroom in core subjects in grades K-3. Waivers are routinely obtained by districts.

H.J.R. No. 19 recites that small class sizes are generally correlated with higher achievement in elementary school students. The Resolution would require the DOE to conduct a study to assess the following: 1) cost of establishing 15 student class size in public schools with a majority of K-3 students eligible for participation in the free and reduced-price lunch program; 2) correlation between current class size data and achievement on the DSTP. The findings would be published by September 30, 2009.

I recommend endorsement of this initiative. I considered a recommendation to require

disaggregation of data for special education students. However, given the variety of classifications, the data would ostensibly add to study complexity and not contribute much to the overall determination of effect of class size on achievement. The GACEC may wish to discuss the pros and cons of such a recommendation.

### 13. H.B. No. 359 [Medicaid Coverage for Adult Dental Care]

This bill was introduced on April 9. It was reported out of committee on April 16. There is a fiscal note.

As background, the Delaware Medicaid program currently covers only children's dental care. The need for adult coverage is well documented. Consistent with the attached AARP article ["Nothing to Smile About: Too few Americans get oral health care, spawning a silent epidemic of dental disease"], an estimated 108 million Americans have no dental insurance, more than twice the number lacking health insurance. The article summarizes evidence that poor oral health may cause or worsen other conditions such as diabetes and cardio-vascular disease. Bacteria from chronic gum infection apparently spread to other organs through the bloodstream.

H.B. No. 359 would add a limited benefit to the Medicaid program. Preventative dental care (defined at lines 7-10) would be covered with a \$10.00 co-pay and \$1,000 annual cap. The cap could be exceeded by another \$1,500 for "urgent dental care" (defined at lines 12-14) if approved under a review process established by the Department.

I have the following observations.

First, the absence of "diagnostic radiographs" from the definition of "preventative dental care" is somewhat surprising. X-rays are covered under the definition of "urgent dental care". Most dentists conduct annual X-rays to supplement oral examinations to assess dental health. Although DHSS could add "diagnostic radiographs" through regulation, the sponsors may wish to assess whether it would be preferable to simply include this routine service in the statute.

Second, I recommend striking the following from lines 27-28: "in cases where multiple conditions which can or are causing pain exist,". This provision creates a conflict with the definition of "urgent dental care" in lines 12-15 and unnecessarily limits urgent dental care to the following: 1) existence of "multiple" conditions versus a single (even acute) condition; and 2) existence of condition causing "pain" irrespective of other serious health impairment. Since the term is already defined in lines 12-15, it would be preferable to simply strike the problematic language.

Third, there is an ostensible error in Section 8 (lines 36-37). The result of the provision is to create the following provision in the affected statute: "Guarantee that assistance provided as medical, including preventative or dental care shall be on a prompt basis,..." The sponsor may wish to consider a corrective amendment.

Subject to the above amendments, I recommend a strong endorsement of the legislation.

14. H.B. No. 386 [Physician-Pharmacist Collaboration]

This bill was introduced on April 24, 2008 and remained in the House Policy Analysis and Government Accountability Committee on May 5, 2008.

This is a somewhat “odd” bill which authorizes a physician and pharmacist to enter into an agreement which permits the pharmacist to “perform functions prescribed in a written protocol”. The scope or type of “functions” is undefined. By inference, I suspect the bill would allow a pharmacist alone to monitor prescriptions and change prescribed treatment without physician approval.

The bill is also vague in defining the preconditions for implementing such an agreement. An agreement could be implemented if any of the following applies: 1) an individual patient agrees or the medical executive committee of an institution “defines the patient population”; or 2) the physician is notified within 24 hours of changes in or as directed in the protocol; or 3) the pharmacist or institution maintains a copy of the protocol and patient records. These standards make little sense. Literally, the second standard would allow no notice to the physician of a change in therapy for a week, month, or longer. Moreover, since the standards are disjunctive, as long as a pharmacist or institution maintains a copy of the protocol and patient records under the third standard, there are no standards for the content of the protocol whatsoever and no provision for notifying the physician of changes in therapy.

I recommend opposition to the bill. It is not well drafted and could jeopardize patient care. The “open-ended” bill ostensibly dilutes the physician’s role in monitoring, directing, and coordinating patient treatment.

15. H.B. No. 381 [Agent Access to Health Care Information]

This bill was introduced on April 23, 2008. It remained in the House Health and Human Development Committee on May 5, 2008.

The bill amends Title 16 Del.C. Ch. 25 which cover “health-care decisions”. The bill adds statutory provisions which clarify the authority of certain agents to serve as “personal representatives” entitled to full access to health care information under HIPAA. The attached HIPAA regulation [45 C.F.R. 164.502(g)] allows a “personal representative” access to health information on the same basis as the “patient”.

The “agents” covered by the bill include the following: 1) an agent appointed by an adult’s valid advance health care directive; 2) an agent/surrogate appointed by an adult through disclosure to a physician or operation of law (Title 16 Del.C. §2507); or 3) a guardian of the person.

I recommend endorsement of the bill subject to consideration of one (1) amendment. A guardian of the person could be appointed for an adult or a minor. See Title 13 Del.C. Ch. 23 and Title 12 Del.C. §3901. The above HIPAA regulation has somewhat different standards for personal representatives of adults versus minors. Therefore, to clarify that Delaware guardians of the person of minors are presumed to have the authority of a “personal representative” under HIPAA, the

sponsors could consider inserting “of a minor or adult” between “person” and “appointed” in lines 5 and 9.

16. S. 1050 [Promoting Wellness for Individuals with Disabilities Act of 2007]

This federal bill was introduced on March 29, 2007. As of May 3, it remained in the Committee on Health, Education, Labor, and Pensions. Its prime sponsor is Sen. Tom Harkin. It has only three (3) co-sponsors. Consistent with the attached summary from the Association of Assistive Technology Programs, there is a House version of the bill [H.R. 3294] with six (6) co-sponsors.

There are three (3) main sections to the Senate bill. Section 2 would require the Architectural Accessibility Board to publish standards to ensure the accessibility of medical diagnostic equipment. Section 3 would establish a wellness grant program for persons with disabilities. Section 4 would enhance training in provision of medical services to persons with disabilities. I have been asked to focus on Section 2.

As background, inaccessible medical equipment is a pervasive problem which undermines access to effective health care for many persons with disabilities. I have attached an informative September 17, 2007 article which provides an overview of the problem. I also attach a 2001 article describing a settlement with a large H.M.O. contemplating the installation and use of accessible medical equipment and removal of architectural barriers. Finally, I attach a 2001 DOJ policy letter to former Sen. Santorum. The letter indicates that, for private medical providers covered by the ADA, “an adjustable table must be provided if it is readily achievable to do so (that is, easily accomplished and able to be carried out without much expense).”

I identified no major concerns with Section 2 of the bill apart from its placement of the statutory standards within 29 U.S.C. 791 (dealing with employment). The Council may wish to consider whether to recommend endorsement by Delaware’s Congressional delegation. Given the paucity of sponsors, and lack of activity on the bill, prospects for enactment may be somewhat limited.

17. Concept Legislation: Universal Design Bill Patterned on Mo. H.B. No. 2459

Earlier this year, legislation was enacted in Missouri which required incorporation of accessible features in newly constructed or rehabilitated “affordable housing units”. An affordable housing unit is defined as one in which a person earning 115% or less of the median income for the person’s county could afford if spending 29% of that person’s gross income annually on such housing.

Earlier this month, some DD Council representatives distributed a “concept” outline of legislation for consideration in Delaware. I have referred this initiative to a DLP senior attorney for analysis since she is more conversant with architectural accessibility issues. I will share her analysis with the SCPD upon receipt.

Attachments

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