

MEMORANDUM

To: SCPD Policy & Law Committee
From: Brian J. Hartman
Re: Recent Legislative & Regulatory Initiatives
Date: March 8, 2010

I am providing my analysis of fourteen (14) legislative and regulatory initiatives in anticipation of the March 11 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive. Parenthetically, I was unable to address all initiatives referred to me, including multiple bills.

1. DSS Final Child Care Subsidy Program Provider Termination Reg. [13 DE Reg. 1211 (3/1/10)]

The SCPD and GACEC commented on the proposed version of this regulation in January, 2010. The Councils observed that the proposed standards appeared straightforward and reasonable and therefore endorsed the initiative.

The Division of Social Services has now acknowledged the endorsement and adopted a final regulation with no further changes.

2. DSS Final Interim Assistance Reimbursement Reg. [13 DE Reg. 1209 (3/1/10)]

The SCPD and GACEC commented on the proposed version of this regulation in January, 2010. The Division of Social Services has now adopted a final regulation with no changes to the regulatory text while nevertheless clarifying issues raised in the commentary.

First, the Councils suggested clarifying which “non-federally funded cash assistance” programs would be covered. DSS responded that only GA and some TANF recipients would be affected at present. However, the regulation is written to provide prospective flexibility to cover other programs.

Second, the Councils identified the issue of competing employer and DSS claims. DSS responded as follows:

Thank you for identifying the potential issue of competing claims against an SSI recipient’s assistance. We will initiate discussions with SSA to determine if a payment priority order is

established and if there is a means to identify competing or additional claims against an SSI recipient's assistance.

At 1210.

Third, the Councils suggested that DSS add a provision clarifying that DSS would reimburse affected beneficiaries for intercepted funds in excess of paid State benefits. DSS responded as follows:

In the past States would receive the entire initial SSI assistance payment and would forward to the client any funds remaining after reducing the payment by the amount of State assistance the client received while their SSI application was pending. This new process results in SSA only sending the amount that represents the assistance received while the SSI application was in review. The remainder of the SSI assistance is paid directly to the client by SSA.

At 1211.

Since the regulation is final, and DSS addressed each concern raised by the Councils, I recommend no further action.

3. DOE Final Tuberculosis Control Reg. [13 DE Reg. 1205 (3/1/10)]

The SCPD and GACEC commented on the proposed version of this regulation in January, 2010. The January 11 GACEC letter is attached for facilitated reference. The Department of Education has now adopted a final regulation incorporating four (4) amendments prompted by the Councils' commentary.

First, while not objecting, the Councils nevertheless suggested that the DOE consider limiting the scope of "school staff and extended services personnel". No change was effected.

Second, the Councils recommended the addition of "within Delaware" and "charter school to district" in Section 2.1.2. The DOE agreed and added both references.

Third, the Councils recommended deletion of the word "show" in Section 4.1. The DOE agreed and deleted the word.

Fourth, the Councils recommended correcting a reference to "asymptomatic" in Section 5.2. The DOE corrected the reference.

Fifth, the Councils suggested a more precise cross reference to Division of Public Health guidelines. The DOE declined to effect an amendment based on the following rationale:

The Department has not incorporated a cross reference to Department of Public Health (DPH) guidelines as these are subject to change. The Department, through health services,

keeps the school nurses and appropriate personnel update to date [sic “updated”] with the current DPH guidelines and criteria.

13 DE Reg. 1205, 1206.

The Councils may wish to send a “thank-you” communication to the DOE for its positive consideration of the commentary.

4. DOE Final Possession, Use or Distribution of Drugs & Alcohol Reg. [13 DE Reg. 1201 (3/1/10)]

The SCPD and GACEC commented on the proposed version of this regulation in January, 2010. I attach a copy of the GACEC’s January 11 letter for facilitated reference.

The regulation was being adopted based on a settlement of a DLP OCR complaint to delete some restrictions on student access to inhalers and epipens. The Councils suggested only one (1) amendment, i.e., substituting “student” for “student’s educational placement” for a variety of reasons compiled in the commentary.

The DOE effected no change based on its observation that the regulatory language is that approved by OCR. I infer that the DOE considers it “safer” to not vary from the exact recitals in the assurances provided to OCR. I recommend no further action.

5. DOE Final Citizen Budget Oversight Committee Reg. [13 DE Reg. 1203 (3/1/10)]

The SCPD and GACEC had commented on the original proposed version of this regulation in November. The DOE then reissued a revised set of regulations in January incorporating multiple changes prompted by the commentary. The Councils proffered only two (2) comments on the January version of the regulation.

First, the Councils noted that training standards had been improved. For example, the training timetable was reduced from 1 year to 3 months after appointment. Moreover, the “2 hour” minimum training standard was embellished with the recital that “additional training may be required from time to time as determined by the Department”. The Councils recommended consideration of reducing the 3-month timetable further and observed that the 2-hour minimum training standard was still weak. The DOE effected no change based on the following rationale:

The Department has provided for additional training as outlined in 6.1. In addition, this section can be revisited and amended based on any feedback from the districts and charter schools and their committee members on this training component.

At 1203.

Second, the Councils reiterated their recommendation that schools provide insurance coverage or right to indemnification. The DOE did not respond to the comment and effected no change.

Since the regulation is final, I recommend no further action.

6. DOJ Final Victims' Compensation Assistance Program Reg. [13 DE Reg. 1213 (3/1/10)]

As the introduction to the regulation indicates, the Governor signed legislation in August, 2009 overhauling the enabling legislation for the Violent Crimes Compensation Board and establishing a Victims' Compensation Assistance Program. The legislation also established the VCAP Advisory Council. The Council is given the authority to "adopt, promulgate, amend and rescind such rules and regulations as are required to carry out [the] chapter." Title 11 Del.C. §9004.

The Council met in November and February and agreed to adopt a procedural regulation to conform to the revised enabling legislation. The Council views the regulation as creating interim standards to guide the VCAP pending a more comprehensive review of standards. Indeed, if S.B. No. 14 is enacted (authorizing compensation for property crimes), amended rules would probably be adopted. The DOJ has determined that the regulation is exempt from public comment under the APA since the amendments are designed to "make them consistent with changes in basic law" pursuant to Title 29 Del.C. §10113.

Although the agency is not soliciting comments, the SCPD may wish to share the following minor observations and recommendations based on my cursory review of the standards:

First, in §1.1, delete the comma after "hereby".

Second, the agency may wish to consider deletion of §4.1.2.

Third, the agency may wish to consider amending §13.1 to read as follows:

(I)n the event that cooperation is refused or denied, VCAP may deny a claim, in whole or part, for lack of cooperation.

This would comport with §21.0. There are circumstances in which the lack of cooperation may relate to only one aspect of a claim. For example, a victim may decline to provide information about mental health treatment but provide information justifying changing a lock. The amendment would clarify that the VCAP's discretion is flexible and not limited to an "all or none" award based on lack of cooperation.

Fourth, there is a "typo" in §13.3 - "physicians's" should be "physician's".

Fifth, the agency may wish to consider whether §17.10 merits revision. For example, §13.4 appears to authorize exceptions to the bar to reopening a case after expiration of 2 years from a final adjudication.

7. Dept. Of Insurance Prop. LTC Insurance Claim Processing Reg. [13 DE Reg. 1181 (3/1/10)]

The Department of Insurance proposes to adopt standards for the prompt, fair, and equitable settlement of claims for long-term care insurance. I have the following observations.

First, in §4.5, second sentence, the word “an” should be “a”.

Second, most of the definitions in §3.0 are extraneous since they are not used in the text of the regulation. Specifically, the terms “institutional provider”, “policyholder”, “insured”, “subscriber”, and “provider” are absent from the balance of the regulation.

Third, overall, the regulation is less comprehensive and “weaker” than the Department’s comparable “Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services” codified at 18 DE Admin Code Part 1310. See attachment. The following are examples.

A. Section 6.0 of the “Health” regulation requires an insurer to pay an undisputed part of a claim and to notify the provider or policyholder why the remaining portion of the claim is not being paid. In contrast, Section 4.0 of the “LTC” regulation effectively authorizes an insurer to simply deny an entire claim even if it only questions a small part of it.

B. Section 7.0 of the “Health” regulation establishes a rebuttable presumption of an unfair practice based on 3 instances of a carrier’s failure to comply with the regulation within a 36-month period. In contrast, Section 4.7 of the “LTC” regulation has no rebuttable presumption and will be more difficult to enforce.

C. Section 4.0 of the “Health” regulation lists some claims that are “clean claims” as a matter of law (e.g. those using Medicare forms). The “LTC” regulation contains no such standards.

D. Section 5.0 of the “Health” regulation clarifies that both a “provider” or “policyholder” may submit a “claim” to which the regulation applies. There is no analog in the “LTC” regulation.

I recommend that the Councils share the above observations with the Department of Insurance and encourage it to adopt standards analogous to the Part 1310 standards. Most of the insureds under LTC policies will be senior citizens who need the protection of comprehensive regulatory protections more than the general population. The Council may wish to share a courtesy copy of the commentary with the Senate Insurance Committee and the House Economic Development, Banking, Insurance, and Commerce Committee.

8. DSS Prop. Cash Asst. Overpayments & FSP Household Claims Reg. [13 DE Reg. 1174 (3/1/10)]

The Division of Social Services currently has a single set of regulations covering overpayments and recovery in the contexts of cash assistance programs (e.g. TANF; GA) and the Food Supplement Program (FSP). DSS is proposing to adopt separate regulatory standards in these contexts. A revised “7000” section will cover cash assistance and a new “9095” section will cover the FSP. I have the following observations.

First, in Section 7003.1, the word “claim” should be deleted.

Second, in other contexts, it is common to waive recovery of overpayments if relatively

small in amount or collection is not cost effective. For example, the Social Security Administration will waive an overpayment up to \$1,000. The FSP authorizes non-collection if the overpayment is \$125 or less [§9095.5] or a claim balance is less than \$25 [§9095.11C]. This concept is absent from Part 7000. Therefore, DSS staff would have no discretion but to process small overpayments of even \$1.00. DSS should consider incorporating an authorization to disregard overpayments if the amount is small and/or collection would not be cost effective.

Third, §7003.1 is subject to confusion. It could be interpreted in two ways based on the use of bullets and co-equal references to “and” and “or”:

A. One interpretation is that there are 3 independent bases for referral to the DOJ:

1. intentional violation and net overpayment exceeds \$1000; or
2. interstate fraud; or
3. repeat offender of \$500 or more.

B. Other interpretation is that there is 1 basis for referral with 3 subparts. Referral would occur only if there is intentional violation characterized by one of the following: 1) net overpayment exceeds \$1,000; 2) interstate fraud; or 3) repeat offender.

A repeat non-intentional offender over \$500 would be referred to the DOJ under the first interpretation but not the second interpretation.

Fourth, the FSP regulation (§9095.10) includes an authorization to “compromise a claim” to facilitate DSS collection within a reasonable period of time. This concept is absent from the Part 7000 regulation for cash assistance overpayments. DSS should consider incorporating an authorization in Section 7004.1 (which covers restitution and reimbursement) to consider “compromise of claim”.

Fifth, I believe the reference to “7004.2 Case Changes” should be deleted. Moreover, there are duplicate references to “7004.1 Methods of Collecting Cash Assistance Overpayments”.

Sixth, §9095.1C) recites that each adult member of a household is responsible for paying an “overpayment” claim. This is based on 7 C.F.R. 273.18(a)(4). See also §9095.6D.2. Section 9095.6C recites that notice of the claim is effected by providing “the household with a one-time notice of adverse action...”. This is based on 7 C.F.R. 273(e). My concern is that a single notice to a “household” may not reach an 18 year old adult living with parents or relatives. The 18 year old would not be notified of the time period to request a hearing which then lapses. The 18 year old would then be subject to wage attachment, state tax intercept, etc. based on §9095.13G without effective notice and opportunity to be challenge the underlying “claim”. Recognizing that DSS is adopting the federal regulation verbatim, it still may be the better practice to send separate notices to each adult member of a household. Otherwise, there may be a lack of due process.

I recommend sharing the above observations with the Division.

9. DSS Proposed FSP Income Deductions Regulation [13 DE Reg. 1174 (3/1/10)]

The Division of Social Services proposes to amend the income deduction standards of the Food Supplement Program. As the “Summary of Proposed Changes” indicates, there are two major changes.

First, DSS is opting to treat child support payments as an income exclusion from gross income rather than a deduction from net income. This favors the obligor and expands eligibility. The relevant federal regulations, 7 C.F.R. 273.9(b)(17) and 273.9(d)(5), provide states with this option.

Second, DSS is opting to allow a shelter deduction of \$143 for homeless households with limited shelter expenses. This should result in an increase in benefits to affected households.

The changes appear in the initial section (bottom of p. 1177) and Par. E.

Since the changes benefit recipients, I recommend sharing an endorsement of the above amendments with DSS subject to clarifying that references to income in the initial section refer to “gross” income, not “net” income. Note that the superseded regulation (e.g. §9060B) explicitly referred to “gross” income.

10. DMMA Prop. Medicaid Prior Authorization Regulation [13 DE Reg. 1166 (3/1/10)]

The Division of Medicaid and Medical Assistance proposes to amend a Medicaid prior authorization “policy”. It proposes to delete an existing policy with specific standards in favor of revising a general policy which then cross references 16 separate policy manuals (§1.21.6).

I have the following observations.

First, DMMA is required to issue its standards as regulations in conformity with the Administrative Procedures Act. See Title 29 Del.C. §§10161(b), 10111, and 10113. The preface to the proposal indicates that DMMA is amending “the Delaware Medical Assistance Program (DMAP) General Policy Provider Manual.” At 1166. The preface then invites comments on “the proposed new regulations”. Id. Unfortunately, it is, at best, unclear that the Manual is a regulation.

The Delaware Administrative Code is available on-line and contains an index for “Title 16 Health & Social Services” at <http://regulations.delaware.gov/AdminCode/title16/index.shtml>. The index lists DDDS, DLTCRP, DPH, DSS, and DSAMH, but not DMMA. The DSS site includes the DSSM (containing Medicaid regulations) but does not include DMAP provider manuals. If someone accesses the DHSS website, clicks DMMA, and then clicks “regulations”, you are referred to the Administrative Code (which lacks a DMMA entry) and the DSSM. Only if you click “manuals”, then “downloads”, then “manuals” again on the DMMA website will you discover the 186-page General Provider Manual and thirty-one (31) policy provider specific manuals containing a host of prescriptive, substantive standards. See attachment.

There are multiple problems with this system:

A. The manuals should be adopted as regulations consistent with the APA since they contain

many substantive standards. If they are regulations, they should appear in the Administrative Code.

B. The manuals are very difficult to locate without an extensive search.

C. If the manuals are not regulations, they can be changed without the benefit of publication for public comment.

Second, Section 1.21.6 contains a list of sixteen (16) contexts in which prior authorization is required. However, it also recites that the list is “not all-inclusive” and directs the reader to the 21 manuals for more specific information. This is not very informative or “user-friendly”. A Medicaid beneficiary will often be unable to determine whether prior authorization is required due to the “maze” of standards and the catch-all recital that the list is “not all-inclusive.” A provider who fails to obtain prior approval when required by these obtuse standards is not paid. See §1.21.2. The unpaid provider may then pressure the beneficiary to pay. Although an informed beneficiary could rely on §1.16.1 protections, this presupposes the beneficiary somehow locates the manual. Moreover, providers can nevertheless pressure payment through other means (e.g. threatening to “drop” as patient).

I recommend sharing the above observations with the Division.

11. DDDS Prop. Appeal Process Regulation [13 DE Reg. 1164 (3/1/10)]

The Division of Developmental Disabilities Services proposes to adopt a regulation defining its appeal process. I attach the current DDDS appeal policy (revised January, 2010) to facilitate comparison.

I have the following observations.

First, DDDS is to be applauded for publishing a proposed regulation in this context as juxtaposed to a “policy”. Although its enabling legislation [Title 29 7909A] contemplates DDDS issuance of regulations, it has only adopted a single regulation since its inception, i.e., its eligibility standards which have been amended a few times. See 16 DE Admin Code 2100.

Second, DDDS should consider overlapping appeal processes apart from Medicaid. For example, if DDDS proposes action covered by the long-term care bill of rights (Title 16 Del.C. §1121) (e.g. changing a roommate in group home or Stockley), the client could initiate a “grievance” with DHSS pursuant to Title 16 Del.C. §1121(28) and 1125. Moreover, if an applicant desired institutional versus HCBS care (covered by §2.1 of the DDDS policy), and the decision were PASARR-related, a DSS hearing is available to even non-Medicaid beneficiaries. See 16 DE Admin Code Part 5000, Section 5304.1. Therefore, it would be prudent to include a non-supplanting provision in the DDDS regulation. Consider the following amendment to §11.0:

11.0 A DDDS Appeal shall not be a pre-requisite for requesting a DSS Medicaid Fair Hearing nor shall the availability of a DDDS appeal supplant or preclude access to appeal and review processes otherwise available under law or Departmental policy.

Third, §3.0 could be interpreted as categorically requiring exhaustion of informal resolution methods prior to appealing to DDDS. This could be problematic since it could result in dismissal of an appeal based on perceived “insufficient efforts” to resolve the dispute informally. Moreover, literally, it would require a client dissatisfied with the outcome of a rights complaint to try to negotiate a different disposition with Chris Long prior to appeal. It would be preferable to “encourage” but not categorically “require” resolution efforts prior to filing for appellate review.

Fourth, in §3.0, the reference to “an appeal DDDS” makes no sense. Consider substituting “an appeal under this regulation.”

Fifth, in §9.0, the comma after the word “appealed” should be deleted.

Sixth, in §10.0, the comma after the word “disposition” should be deleted.

Seventh, in §4.0, consider adding the following amendment: “The implementation..., unless it has already been implemented *or by agreement of the appellant and DDDS.*” There may be situations in which the parties agree to “roll back” action pending the processing of the appeal. It would be preferable to authorize DDDS discretion in this context.

Eighth, under §5.0, the 90 day time period to request a Medicaid hearing is not tolled during the pendency of the DDDS appeal. It would be preferable to reach an accord with DSS that would allow tolling. See, e.g., attached January 27, 2000 policy letter from Medicaid Director, Phil Soule, authorizing tolling of 90 day Medicaid fair hearing request period during pendency of internal MCO review.

Ninth, in §2.4, it would be preferable to insert “limitation” after “reduction,”. Compare 18 DE Admin Code Part 1403, §2.0, definition of “adverse determination” and 18 DE Admin Code Part 1301, §2.0, definition of “adverse determination”.

Tenth, in §2.0, it would be preferable to include the following: “2.6. Decisions involving the content or implementation of an ELP”.

Eleventh, in §2.0, it would be preferable to include a “catch-all” such as “2.7 . Other adverse DDDS action or refusal to act with significant impact on appellant.”

I recommend sharing the above observations with DDDS. A courtesy copy could be shared with Secretary Landgraf, the ARC, and Autism Delaware.

12. DOE Proposed Unit Count Regulation [13 DE Reg. 1158 (March 1, 2010)]

The Department of Education is proposing to adopt several revisions to its unit count regulation. I have the following observations.

First, §§1.3, 4.1.4., and 4.1.11 disallow counting of a student with a disability unless the student has an IEP in effect during the last week of school in September. There is some “tension” between this requirement and 14 DE Admin Code Part 925, §23.2 which provides schools 30 days to develop an IEP after initial identification. Thus, a student could be identified in early September, be awaiting development of an IEP, and not be counted as a student with a disability resulting in lack of qualification for federal IDEA funds. The requirement that a student have an IEP to be counted as a student with a disability also squarely conflicts with 14 Admin Code Part 925, §6.5.1, which recites as follows:

6.5.1. A child shall be entitled to receive special education and related services, and shall be eligible to be counted as a special education student for purposes of the unit funding system established under 14 Del.C. Ch. 17, when the child’s team has determined that the child meets the eligibility criteria of at least one of the disability classifications in this section, and by reason thereof, needs special education and related services.

At a minimum, the DOE may wish to consider allowing newly identified students to be counted pending development of an IEP.

Second, §2.2 recites that “students with multiple disabilities shall be reported in the category that corresponds to their major eligibility category.” To conform to 14 DE Admin Code Part, 925, §6.5.3, as well to conform to historical language, the DOE should consider referring to “primary disability classification” or “primary eligibility category”.

Third, in §1.3, the DOE deleted the requirement that students be reported by grade level. However, §2.4 still requires reporting by grade level. The DOE may wish to consider whether an amendment is necessary to reconcile these provisions.

Fourth, §3.1.3 misstates the legal standard for “good cause” transfer of an initial year charter school student to a another public school. Section 3.1.3 recites as follows:

3.1.3. Districts and Charter Schools enrolling an intra-state transfer student during the last 10 school days of September during which students are required to be in attendance shall first determine if the student is currently obligated under a choice agreement or first year charter agreement before enrolling the student. If said obligation exists, “good cause” must be agreed upon by the sending and receiving district/charter school before the receiving district/charter school can enroll the student.

[emphasis supplied]

In contrast, Delaware statutory law identifies “good cause” for initial year transfer from a charter school as including several bases apart from the mutual agreement of the sending and receiving schools. See Title 14 Del.C. §506(d). An initial year charter student can withdraw from charter school “as of right” and irrespective of approval of the exiting charter school and the

receiving school based on changes of residence, marital status, guardianship, etc.

Fifth, §4.1.6.2, as amended, makes no sense. It reads as follows:

4.1.6.2. Students shall the level of special education services as defined by the current IEP.

Sixth, the word “and” is duplicated in §4.1.11. It reads “(s)tudents who have been properly identified; and and have an IEP...”

Seventh, §6.2.1 disallows inclusion of students placed in distance education/twilight programs for behavioral reasons unless “currently suspended indefinitely or expelled by the district and enrolled in the district’s alternative placement program.” The reference to “indefinite suspension” is odd. Suspensions of students, particularly special education students, cannot be indefinite. See 14 DE Admin Code Part 926, §30.2. Moreover, students may be enrolled in an alternative placement program for behavioral reasons without being suspended or expelled. See Title 14 Del.C. §§1604 and 1605.

Eighth, §6.2.3 is convoluted and difficult to understand.

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

13. H.B. No. 326 (Sexual Abuse by Health Care Provider)

This bill was introduced on February 18. As of March 3, it remained in the House Economic Development, Banking, Insurance, and Commerce Committee.

The bill would amend the statute of limitation for recovery of damages against health care providers for personal injuries arising from medical negligence. It is intended to have two (2) effects: 1) prospective elimination of any statute of limitation on a civil action based on sexual abuse of a patient by a health care provider; and 2) opening of a 2-year window for patients to file such actions if the current statute of limitation has already lapsed.

I have the following observations.

At first blush, amending the medical malpractice statute of limitation in this context is ostensibly somewhat odd. In effect, a suit for intentional personal injury is characterized as a limited exception to negligence-based malpractice. However, the bill would also authorize claims against the perpetrator’s employer based on a finding of gross negligence. By incorporating the provisions in the malpractice statute, it may facilitate claims against malpractice insurers.

Second, there is a minor error in line 12. The word “owned” should be “owed”.

Third, as the synopsis indicates, the bill is patterned on the Child Victim’s Act, S.B. No. 29,

which was enacted in 2007. That legislation similarly eliminated any statute of limitation against an adult for child sexual abuse and opened a 2-year window to file suit if the former statute of limitation had lapsed. I attach a July 10, 2009 article which provides information about that legislation which resulted in 170 lawsuits. A prominent issue under the Child Victims Act was its application to “public” entities. In 2008, the House passed H.B. No. 242 to clarify the Act’s application to the State and political subdivisions of the State, including school districts. The bill was never released by the Senate Executive Committee. The SCPD, as reflected in the attached June 16, 2008 memo, supported H.B. No. 242. Since H.B. No. 326 adopts the same language as the Child Victim’s Act, its application to public entities may be unclear. The sponsors may wish to clarify intent to resolve any ambiguity.

Fourth, I assume that one catalyst for the bill is the set of recent allegations against a Sussex County pediatrician. The bill would allow civil suits against the pediatrician for sexual abuse which would have been time-barred by the current statute of limitation. It would also allow civil suits, based on gross negligence, against employers and entities with a duty of care.

I recommend endorsement of the bill subject to correction of the error in line 12 and consideration of clarification of the extent of the bill’s application to public entities.

14. S.B. No. 204 (Autism Spectrum Disorders Insurance Coverage)

This bill is patterned on a national model promoted by Autism Speaks. Consistent with the attached February 23, 2010 update, 15 states have now passed similar legislation, including Pennsylvania and New Jersey. In a nutshell, the bill requires private health insurers to cover the costs of diagnosis and treatment of autism spectrum disorders. Coverage of up to \$50,000 for applied behavior analysis (defined at lines 21-24 and 111-114) for persons with such disorders would be required. Consistent with the attached articles, the advantages of early identification and intervention for persons with autism spectrum disorders are well documented.

The DLP provided technical assistance to Autism Delaware in editing earlier drafts of the bill. It is generally well written and merits endorsement subject to the following minor suggestions.

First, lines 46 and 136 ignore the authority of an advanced practice nurse to prescribe medicine pursuant to Title 24 Del.C. §1902(b). It would be preferable to substitute “practitioner” for “physician”.

Second, in lines 83 and 172, the word “and” before the phrase “individual plan for employment” should be “an”.

Third, the definitions of “psychological care” in line 50-52 (covering individual policies) and lines 140-141 (covering group policies) are different. The former reference includes services provided by “a school psychologist appropriately licensed in their state of employment”. Delaware does not license “school psychologists”. They are “certified” by the Department of Education. See

Title 24 Del.C. §3519(d). A Delaware licensed psychologist requires a doctoral degree [Title 24 Del.C. §3508] while a Delaware certified school psychologist does not require a master's or doctoral degree [14 DE Admin Code Part 1583, §3.0]. The sponsors should consider an amendment to effect consistency in the definitions of "psychological care".

In sum, I recommend a strong endorsement of the bill accompanied by identification of the above technical oversights.

Attachments

F:\pub\bjh\legis/p&l\2010\310bils
2g:p&l\310bils

2g:p&l\310bils