

## MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Legislative, Regulatory & Policy Initiatives

Date: March 5, 2012

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

### 1. DSS Final Fair Hearing Notice & Response to Hearing Request Reg [15 DE Reg. 1339 (3/1/12)]

The SCPD and GACEC commented on the proposed version of this regulation in January, 2012. A copy of the January 24 GACEC letter is attached for facilitated reference. The Division of Social Services is now adopting a final regulation with two (2) amendments prompted by the Councils' commentary.

First, the Councils noted that use of the term "case record" could be misconstrued to mean the "hearing record". The Councils recommended that the State adopt the federal term, "case file", along with a definition of "case file" to include "the totality of all files and records on a client within the custody, control or possession of an agency in electronic, paper, or other format." As a compromise, DSS amended the reference to read "the agency and/or MCO case record".

Second, the Councils recommended deletion of the word "State" from the heading of §5312. DSS agreed and effected the amendment.

Since the regulation is final, and the Division incorporated amendments in response to each of the Councils' comments, I recommend no further action.

### 2. DSS Final Fair Hearing Regulation [15 DE Reg. 1343 (3/1/12)]

The SCPD and GACEC commented on the proposed version of this regulation in January, 2012. A copy of the January 24 GACEC letter is attached for facilitated reference. The Division of Social Services is now adopting a final regulation incorporating several amendments prompted by the commentary.

First, the Councils recommended a change in punctuation in the definition of

“abandonment”. DSS agreed and effected the amendment.

Second, the Councils objected to inaccurate references to “advance notice period” and “timely notice period”. DSS declined to amend the references.

Third, the Councils noted the omission of references to representation by non-attorneys. DSS agreed and inserted a conforming amendment.

Fourth, the Councils identified inconsistent definitions of “fair hearing summary” and “hearing summary”. DSS added an amendment to ensure conformity between the definitions.

Fifth, the Councils shared their concern that the regulation literally allowed individual health care providers to be parties to hearings. DSS deleted the problematic language.

Sixth, the Councils questioned the definition of “State Presenter”. DSS deleted the definition.

Seventh, the Councils objected to a categorical requirement that agencies pursue repayment if the beneficiary does not prevail at hearing. DSS modified the requirement to only apply to food benefits and cash assistance, not Medicaid.

Eighth, the Councils strongly objected to the following provision: “The hearing officer may make a negative assumption when a party declines to give testimony under a claim of privilege”. DSS agreed and deleted the reference.

Ninth, the Councils objected to a recital that “privileges are waived by a claimant if the information is relevant to the defense of the action or inaction under appeal”. DSS agreed and deleted the reference.

Tenth, the Councils objected to an authorization for the parties to “discuss the results of the hearing with the hearing officer”. DSS agreed and deleted the reference.

Eleventh, the Councils characterized the section on continuances as overly restrictive. DSS adopted multiple amendments to the section.

Since the Division effected amendments based on ten (10) of eleven (11) comments, I recommend issuance of a “thank-you” letter.

### 3. DMMA Final Child Dental Services Reimbursement Reg. [15 DE Reg. 1333 (3/1/12)]

The SCPD and GACEC commented on the proposed version of this regulation in January, 2012. A copy of the January 24 GACEC letter is attached for facilitated reference.

The Councils endorsed the regulation subject to two (2) recommendations.

First, the Councils noted that the regulation authorized DMMA to adjust the maximum

allowable amount if “not appropriate for the service provided”. The Council asked that DMMA clarify that this could result in enhanced reimbursement for services rendered to a particularly “involved” individual (e.g. persons requiring acclimation sessions at Practice Without Pressure). DMMA rejected the suggestion:

Agency Response: Practice Without Pressure is enrolled and paid like any other dental provider. Acclimation is part of a continuum of behavior management approaches which are considered part of the service being provided.

At p. 1336.

Second, the GACEC solicited the number of dental providers to provide a baseline to determine if the new reimbursement methodology results in a reduction in the number of participating dental providers. DMMA identified 296 providers (at p. 1336). Another commenting entity noted that approximately 65% of dentists participate in the Delaware Medicaid program.

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

4. DMMA Prop. Medicaid Provider Screening & Enrollment Reg. [15 DE Reg. 1273 (3/1/12)]

The Division of Medicaid and Medical Assistance proposes to amend the Medicaid State Plan to include certain assurances related to enrollment of providers.

As background, CMS issued regulations in February, 2012 which are effective March 25, 2012 implementing changes in the U.S. Code. CMS provided states with a template for certifying compliance within the respective state plans. Delaware is now providing the assurances contained in the template.

Since DMMA is essentially adopting a mandatory change in its State Medicaid Plan prompted by CMS, I recommend endorsement.

5. DMMA Prop. Disproportionate Share Hospital Regulation [15 DE Reg. 1265 (3/1/12)]

The Division of Medicaid and Medical Assistance proposes to expand eligibility for Medicaid disproportionate share hospital funds.

As background, the regulation notes that federal law requires states to offer disproportionate share hospital (DSH) payments to qualifying hospitals serving a large number of Medicaid and uninsured patients. There is both an overall state cap on funds and a per-hospital cap on funds. Delaware’s eligibility criteria have been somewhat restrictive. As a result, only the Delaware Psychiatric Center has applied and qualified for DSH funds. DMMA hopes the new eligibility standards will allow other hospitals to qualify for funds. State matching funds are included in both the FY12 budget and proposed FY13 budget. At 1267.

I have the following observations.

First, the regulation prioritizes payments to DPC in the event of insufficient funds to distribute to qualifying applicants. At 1271, Section C) I). This is understandable, especially given the costs to implement the DOJ-DHSS settlement agreement.

Second, there is some “tension” between the authorization for a “psychiatric hospital” to qualify for DSH funds (p. 1271, bottom) and the categorical requirement that the psychiatric hospital “be a public psychiatric hospital (owned or operated by an agency of Delaware State government)” (p. 1270, Section (d)). Thus, the latter section would bar Rockford or Meadowood from qualifying for DSH payments as a psychiatric hospital. The only exception is eligibility for a modest \$10,000 if the psychiatric hospital is a Medicaid MCO provider (p. 1272, Section 4). It’s unclear why private psychiatric hospitals should be treated differently than acute care hospitals. Perhaps the State prefers payments to non-profit providers (p. 1270, top) and psychiatric hospitals may be predominantly “for profit” providers.

The expansion of eligibility criteria merits endorsement since it may prompt hospitals to be more likely to treat Medicaid patients and offer uncompensated care. At the same time, the qualifying criteria are complex. I therefore recommend endorsement of the concept of the initiative.

6. DSS Prop. Food Supp. Program Drug Disqualification Reg. [15 DE Reg. 1277 (3/1/12)]

As background, the Governor signed S.B. 12 on June 22, 2011 which removed a bar on Food Supplement Program eligibility of convicted drug felons. The Councils supported that legislation given the correlation between drug usage and mental health conditions. In October, 2011, the Division of Social Services issued a proposed regulation implementing the new law. In their commentary on that regulation, the SCPD and GACEC noted that DSS had overlooked 16 DE Admin Code 2027 which retained the drug felon disqualification. In adopting a final regulation, the Division agreed to issue a new regulation to cover the oversight. [15 DE Reg. 451 (October 1, 2011) (proposed); 15 DE Reg. 1027, 1028 (January 1, 2012) (final)].

The Division is now issuing a proposed regulation eliminating the drug felon disqualification from 16 DE Admin Code 2027. The regulation is straightforward and merits endorsement.

7. DOE Prop. Teacher Appraisal Process Regulation [15 DE Reg. 1245 (3/1/12)]

The Department of Education previously issued a regulation covering teacher appraisal in October, 2011. The Councils commented on that regulation which became final in December, 2011 [15 DE Reg. 409 (October 1, 2011) (proposed); 15 DE Reg. 833 (December 1, 2011) (final)].

Consistent with the attached articles, the teacher appraisal process is highly controversial. In particular, many educators object to being assessed on student performance. In July, 2011, the Department of Education secured a one-year delay in using student data to rate teachers. The

regulation adopted in December reflected that exemption for the 2011-12 school year. Since then, differing viewpoints have been presented in the press. For example, the attached January 17, 2012 News Journal article includes the following critique presented to the State Chamber of Commerce:

Finally, teaching is a true profession, much like doctors, lawyers and engineers. These are professions where people are expected to achieve specific outcomes: cure the patient, win the trial, build the bridge or educate the child, but the practitioner must achieve success in ever changing circumstances and conditions. Yet the teacher's union, DSEA, insists on personnel practices that are more appropriate for a factory floor than in a profession like teaching. It is a philosophy where seniority drives assignments, transfers and layoffs; and where salaries are based upon years of service and educational level, not on achievements in the classroom.

Similarly, the attached January 26, 2012 article includes the following observation from the Rodel Foundation based on the observation that the outgoing performance evaluation system found 98.5% of public school educators were "effective":

Any system where 99 percent of the people get a satisfactory rating to me suggests it's not good for the teachers, it's not good for the public and it's not good for children.

On the other hand, the same article includes the following educator concerns:

I can't control if a student has had breakfast, if they have had a good night's sleep, if the parents provide them with a quiet place to read. Those factors I can't control,...I can control the hour and a half...I would be happy to be held accountable for the work I do on that front.

Special-education teacher Cindy Pochomis, who works at the Richardson Park Learning Center, worries that what she does will never be accurately reflected in the test. The children at her school have very high needs - physically and emotionally - and she's concerned that fewer teachers will want to take jobs in her field if teachers are rated based on how these children do on standardized assessments.

The March proposed regulation apparently continues the exemption for teachers from any adverse effects of student DCAS scores. The only exception is that the results can be considered to determine if a newly defined "DCAS Teacher" qualifies for a "highly effective rating" (§5.2). The results would not be used to determine if a "non-DCAS Teacher" is "highly effective" (§5.2.1.1).

Given the ostensible minor effect of the initiative, I recommend taking no position on the regulation.

#### 8. DOE Prop. Specialist Appraisal Process Regulation [15 DE Reg. 1254 (3/1/12)]

The Department of Education previously issued a regulation covering specialist appraisal in

October, 2011. The Councils commented on that regulation which became final in December, 2011 [15 DE Reg. 417 (October 1, 2011) (proposed); 15 DE Reg. 835 (December 1, 2011) (final)]. The DOE is now proposing some discrete amendments to the standards.

The regulation includes an exemption from counting “student improvement” in the assessment of a specialist in the 2011-12 school year (§5.2). The rating of “highly effective” is not available to specialists for the 2011-12 school year (§6.2.1.1). Specialists qualify for an “effective” rating by earning a satisfactory rating in four appraisal components apart from student improvement (§6.2.2.3). A specialist qualifies for a “needs improvement” rating based on a satisfactory rating in 2 of 4 appraisal components apart from student improvement (§6.2.3.3). A specialist qualifies for an “ineffective” rating based on a satisfactory rating in 0-1 of the 4 appraisal components apart from student performance (§6.2.4.3). An improvement plan is available based on unsatisfactory ratings (§§8.1-8.2).

I recommend endorsement subject to reiteration of the Councils’ observation on the October regulation that the categories are euphemistic and overly generous by characterizing a specialist with a satisfactory rating in 2 of 4 contexts as “needs improvement” and a satisfactory rating in 0 or 1 context as “ineffective”.

#### 9. DOE Prop. Administrator Appraisal Process Regulation [15 DE Reg. 1259 (3/1/12)]

The Department of Education previously issued a regulation covering administrator appraisal in October, 2011. The Councils commented on that regulation which became final in December, 2011 [15 DE Reg. 424 (October 1, 2011) (proposed); 15 DE Reg. 836 (December 1, 2011) (final)]. The DOE is now proposing to remove the exemption for the 2011-12 school year for rating an administrator as “needs improvement” or “ineffective” based on 5 evaluative components, including student improvement (deleted §7.2). The DOE also proposes to remove an exemption from development of an improvement plan based on unsatisfactory student improvement (deleted §8.2). The DOE offers no explanation for the changes.

Since the changes may enhance administrator accountability, I recommend endorsement.

#### 10. DLTCRP Prop. IBSER Regulation [15 DE Reg. 1264 (3/1/12)]

The SCPD, GACEC, and DDC commented on an earlier version of this proposed regulation published last Fall [15 DE Reg. 600 (11/1/12)]. I attach the November 21, 2011 DDC letter for facilitated reference. It contains forty-four (44) comments. Rather than adopt a final regulation, the Division of Long-term Care Residents Protection is issuing a revised set of proposed priorities. I have the following thirty-two (32) observations.

1. The revised regulation incorporates many of the Councils’ recommendations, including the following: inclusion of “purposes” and “authority” sections (§§1.0 and 2.0); improving the

definition of “legal representative” (§3.0); clarifying the application of the regulation to day program participants (§3.0); including an accessibility reference in §6.1.2; authorizing non-glass shower doors (§6.5.3); disallowing children sharing rooms with adults (§6.6.15); requiring notice near phones of the DLTCRP telephone number (§6.12.3); requiring carbon monoxide detectors (§8.3); requiring certain information be included in agency website (§10.2); adding a general 5 year retention of records standard (§11.1.3); requiring maintenance of fire and comprehensive general liability insurance (§12.0); eliminating “criminal justice” as a relevant background degree (§13.2.4); requiring training in safe and effective behavior management techniques (§14.3.3); requiring monthly HRC meetings (§17.1.1.3); and requiring retention of incident reports for four years (§24.2).

2. The title to §1.0 is “Purpose Definition”. This makes no sense. Moreover, there is still no “operational” language reciting that the standards apply to IBSERs and no “purposes” language despite the title. Compare the neighborhood home regulation, 15 DE Reg. 968 (January 1, 2012), §1.0:

The purpose of these regulations is to provide a sequence of expectations for services rendered by the Neighborhood Home provider and a system for Neighborhood Home providers to be accountable to the Division of Long Term Care Residents Protection (DLTCRP) and the Division of Developmental Disabilities Services (DDDS).

[emphasis supplied] There is no analog in the IBSER regulation.

I recommend changing the heading to “Purpose” (deleting “Definition”) and adding the following sentence:

The purpose of these regulations is to provide a set of expectations for the operation of IBSERs and ensure accountability to the Division of Long Term Care Residents Protection (DLTCRP).

3. The definition of “mechanical restraint” ostensibly seeks to exempt equipment and devices with a medical basis (e.g. prone stander; bed siderails). However, the definition would literally authorize a non-medical, undefined mental health “therapist” to authorize any form of mechanical restraint to prevent SIBS. At a minimum, the reference should be changed to occupational or physical therapist.

4. The definition of “mechanical restraint” is otherwise problematic. Literally, any equipment used to deter SIBS is per se not a “restraint”. As a consequence, it would be exempt from inclusion in the SBS plan (§20.2.2), review by the Behavior Management Committee (§§18.2 and 18.3), and review by the HRC (§§17.1.2 and 18.3). Thus, use of a helmet, mittens, or other AT would be exempt from many procedural safeguards. This is not “best practice” and is inconsistent with DDDS policy (e.g. DDDS HRCs review use of helmets, mittens, and AT used for SIBS prevention).

5. In the definition of “physical restraint, it would be more logical to transfer the second sentence (barring certain forms of restraint) to §20.11 (containing list of 12 forms of prohibited

restraint). Moreover, the reference to “free movement of the resident’s diaphragm or chest that restricts the airway” could be improved. Some states have focused on pressure on certain body parts as more instructive. Consider the following prohibition: “Restraint that interferes with the resident’s ability to breath or places weight or pressure on the student’s throat, neck, lungs, chest, sternum, diaphragm, or back.”

6. There is a definition of “seclusion” but no regulation which addresses it. The November version of the regulation explicitly barred use of seclusion. See attached DDC comments, Par. 20. The Bill of Rights Act explicitly bars “involuntary seclusion” without exception [Title 16 Del.C. §1121(24)]. Therefore, the IBSER regulation must conform to the statute and the ban should be reinstated. Parenthetically, this is consistent with “best practice”. See Section 4 of attached S. 2020 introduced by Sen. Harkins in December, 2011.

7. The definition of “Specialized Behavior Support Plan” is defective. Literally, the plan is expected to include a restraint to a resident to protect the resident from others. Why would an agency use a restraint on an individual to prevent his/her victimization from others? Immobilizing the victim will only exacerbate the victimization.

8. In §5.5, delete the comma.

9. The DLTCRP Neighborhood Home regulation imposes the following obligation:

4.2.7.2. The Policy Memorandum 46 (PM 46) policy for reporting abuse, assault, attempted suicide, mistreatment, neglect, financial exploitation and significant injury is followed.

15 DE Admin Code 968, §4.2.7.2 (January 1, 2012) (proposed). There is no analog in the IBSER regulation. The DLTCRP could consider inserting a similar recital as a new §5.10 or within §19.0.

10. In the commentary on the November version of the regulations, the Councils provided a multi-pronged critique of allowing a 16-bed facility. See, e.g., Par. 11 of attached DDC comments. The new regulation reflects a compromise in which 16-bed facilities are “grandfathered” and new facilities must have no more than 10 residents. Segregated residential settings with 10 or 16 individuals per unit are not consistent with best practice and may violate the ADA. Consider the DHSS-DOJ DPC Settlement Agreement signed in July, 2011. That Agreement, which is based on the DOJ’s interpretation of the ADA, does not contemplate large congregate living arrangements. Rather it restricts supported housing to 2 individuals per unit with a separate bedroom for each resident (§II.E.). A 16-bed facility in which adult residents are “squeezed” into timely rooms (§6.6.1) with age-inappropriate bunk beds (§6.6.11) smacks of “warehousing”.

11. Section 6.2.2 should be amended to include a reference to “legal representative” since the list of authorized visitors entitled to meet in private is literally limited to four types. Compare Title 16 Del.C. §1121(11)

12. The Councils had previously objected to 200 square foot bedrooms with 4 individuals. See attached DDC letter, Par. 14. New §6.6 contains a “grandfather” provision for bedroom occupancy. New facilities will require 80 square feet for single occupancy and 130 square feet for



double occupancy. This is still less floor space than required in group homes for double occupancy for persons with mental illness. See 16 DE Admin Code 3305, §12.2.2 (requiring 160 square feet for double occupancy). Likewise, the latter regulation disallows counting areas with lockers, wardrobes, vestibules, and alcoves. This limit is absent from the IBSER regulation. At a minimum, double occupancy standards should be no less than mental health group home standards (160 square feet exclusive of closets, lockers, wardrobes, vestibules and alcoves).

13. In §6.6.11, the authorization for adults to sleep in bunk beds is not age-appropriate.

14. In §6.5 or 6.7, the Division may wish to consult a dental expert. It may be appropriate to require a facility using well water to offer a fluoride rinse to some residents. Medicaid does not cover adult dental care and DDDS struggles with dental remediation which could be reduced through access to fluoride rinse in the absence of fluoridated water.

15. The DLTCRP Neighborhood Home regulations [15 DE Reg. 968, §4.6.6.7 (January 1, 2012) (proposed)] contain the following requirement: “(n)on-perishable food and capacity to store 1 gallon of potable water per person per day for at least a 72-hour period is present”. The Division could consider adding a similar water storage capacity standard to §7.10.

16. In §13.2.3.1, a direct care worker is required to be 21 years of age and possess a high school diploma. The Division may wish to consider the merits of substituting “18” for “21”. The change would allow college students (e.g. in human service fields such as psychology) to work part-time as direct care workers. Alternatively, the regulation could allow individuals to be employed as direct care workers between the ages of 18-20 only if they are college students in a human services field (defined in §§13.2.1.1, 13.2.4.1 and 13.2.5.1).

17. In §14.5.2, substitute “resident” for “patient”.

18. Section 17.0 merits reconsideration. The only agency to which the IBSER regulation applies presented its first of many cases to the DDDS HRC on February 29, 2012. The DDDS HRC does not include individuals with the qualifications listed in §17.1.1.2, including a licensed physician and licensed psychologist. On the other hand, the standards for the “internal” HRC are weak in the context of impartiality. DDDS amended its policy many years ago to require 100% membership by individuals external to DDDS. The IBSER regulation only requires a majority of external members and the “spirit” of this regulation may be undermined in practice by including a recent agency retiree as an “external” HRC member.

19. Section 18.1 refers to “the licensee’s clinical director”. There is no requirement that an agency have a “clinical director” and no definition of a “clinical director” in §13.0.

20. Although §20.7 contains a reference to data collection, it would be preferable to explicitly include a reference to presentation of data to the BMC in §18.2.1.

21. In §19.2, it would be preferable to include a reference to “contractor”. The only agency currently subject to the IBSER regulation uses physician contractors.

22. Section 20.2.1 may be the most problematic standard in the regulations. It authorizes restraint based on the following benchmark:

The resident is exhibiting a problem behavior that is so severe that it poses a risk to the safety and wellbeing of the resident or others;

Authorizing the use of restraint based on the “safety and wellbeing” of the resident or others is amorphous and an invitation to overuse of restraint. If restraint is authorized by government, it is commonly restricted to an imminent risk of serious bodily injury to self or others. See, e.g., attached S.2020, Section 4. The concept of “imminency” is incorporated into §20.8.3 as material to termination of restraint but is absent from the standards for initiation of restraint. Moreover, if government does authorize use of restraint, it is also common to ban use of mechanical restraint. See S. 2020, Section 4. Use of straight jackets, wrap mats, rope and tape to restrict access to body parts is viewed as inherently intrusive. Cf. the attached February 12, 2012 News Journal article describing prosecution of a teacher for false imprisonment and endangering the welfare of a child based on tying the hands of a child with autism.

23. Section 20.3 refers to an undefined “SPTteam” which includes an undefined “properly credentialed professional”. It would be preferable to add “, licensed” after “credentialed” since agencies may otherwise use marginally qualified “behavior analysts” without an advanced degree to develop an SBS Plan.

24. The only agency to which the regulation will apply uses videocameras throughout its buildings. It would be preferable to amend §20.9 to require maintenance of any recorded episode of restraint. Such a recording would be of diagnostic and training value for the SBTeam, HRC, and administration. It may also be of value to the DLTCRP.

25. Section 20.9.1 contemplates “clinical review and approval for interventions longer than 15 minutes”. Who has the authority to issue the approval? Is a “direct care worker” with high school diploma (§13.2.3.1) a “clinician” who can approve extended restraint? Within the DDDS HRC, it is common to require approval by the agency’s clinical director or alternate. The IBSER regulation refers to a clinical director in §18.1 but does not require a clinical director (§13.0) and does not define a “clinical director”.

26 Section 20.9.2 requires “(a)pproval by a clinician within one business day of an intervention when a restraint utilization event is less than 15 minutes.” There are two concerns with this provision. First, there is no definition of a “clinician”. Second, it is somewhat odd to retroactively “approve” an intervention a day after it was employed unless the intent is to prompt review to deter misuse.

27. It would be preferable to include a new §20.11.13 to read as follows: “Consistent with 34 C.F.R. §§300.2 (c) and 300.146, use of restraint or forms of aversive techniques on adult IDEA-

funded students which violate applicable law or regulation of the public IDEA funding agency.

28. Since the regulation covers adults, the reference to “parents” in §22.6 is inapposite. It would be preferable to refer to the consent of “the resident or legal representative” rather than “parents or legal guardian”.

29. Although there is a short “universal precautions” section (§23.0), there is no section which addresses laundry. In practice, the facility could commingle the laundry of 16 individuals in cold water and spread disease. Compare 16 DE Admin Code 3201, §7.6.

30. Section 24.1 could be improved by including the following after “witnesses;”: “the existence of any video record of the incident”.

31. In §§24.4.2 and 24.4.4, it is inconsistent to require reporting of resident - resident emotional abuse while exempting reporting of resident - resident physical abuse in the absence of injury.

32 Section 24.4.11 only requires reporting of medication errors unless the error causes discomfort, jeopardizes health/safety, or requires 48 hours of monitoring. The exceptions provide subjective bases to withhold reporting to the Division.

I recommend sharing the above observations with the DLTCRP, DHSS Secretary, and DSAMH and DDDS Directors.

#### 11. DSAAPD Non-Medicaid PAS Program Co-Pay Policy (2/27/12 Draft)

The Division of Services for Aging & Adults with Disabilities presented draft Personal Attendant Services (PAS) program regulations to the SCPD at the Council’s February 27 meeting. The Council agreed to compile comments by March 8, the date of the P&L meeting.

I have the following recommended edits.

1. In Section C, substitute “countable” for “net” in both sentences. This would conform to Section J.

2. In Section D, insert “countable” before “income”.

3. In Section E.3., it would be preferable to include an explicit reference to the exemption from counting the value of a CarePlan trust pursuant to Title 12 DeI.C. §4009. The Delaware CarePlan trust is a common form of trust for individuals with disabilities.

4. In Section I.1., insert “gross” prior to “earned”.

5. In Section K, fifth sentence, consider inserting “State” prior to “cost” to clarify that the financial responsibility is to pay what the State pays for the service, not a market cost or provider cost.

I recommend sharing the above suggestions with the Division.

## 12. H.B. No. 246 (Yellow Dot Medical Information Alert Program)

This bill was introduced on January 17, 2012 and was released from the Health & Human Development Committee on January 18, 2012. As of March 1, it awaits a House vote.

The legislation would direct the Division of Public Health to create a “Yellow Dot” medical alert program. There is no fiscal note. The Division would make available “yellow dot folders” with information that individuals could keep in their glove compartment. The individual would choose the scope of information to include. The “menu” includes name, address, photo, emergency contact phone number, medical history, allergies, prescriptions and dosage, and physician name and phone number. The individual can then attach a yellow dot sticker in the lower left corner of the rear window of the vehicle to alert emergency responders that the information of the driver and/or frequent passengers is in the glove compartment.

The attached Committee Report expressed two (2) reservations: 1) identity theft; and 2) liability of first responders. Two amendments have been added to the bill to clarify that the scope of information listed in the folder is completely voluntary and individually determined by the participant and that responders are exempt from liability in the absence of gross negligence.

I am including several articles which describe the operation of this program in other states. For example, the Paoli Hospital in Pennsylvania, a trauma center, adopted a similar program in September, 2011. The May 24, 2011 USA Today article indicates that the first “yellow dot” program was adopted in Connecticut in 2002 and has spread to counties in at least eight (8) other states (Kansas; Illinois; Iowa; Minnesota; Massachusetts; Virginia; Alabama; and New York). First responders have generally endorsed the program which provides quick access to medical information. The photo helps link the information to the person in need of treatment. It is recommended that participants fill in information in pencil for updating as medications, physician information, etc. change. Social Security numbers and dates of birth are omitted to reduce prospects for identity theft.

I recommend endorsement. It is an entirely voluntary program which individuals can tailor to their needs. It could be a “life saver” in many circumstances. For example, if an individual needs a blood transfusion, the blood type would typically be listed in the folder. If presenting symptoms could be correlated with multiple causes (e.g. drugs or seizure), the folder would help a responder determine that the symptoms are more likely the result of an underlying seizure disorder. If a person is allergic to a particular medicine, the responders would know not to administer that medicine which could otherwise result in adverse reaction or death. In the context of a traumatic brain injury caused by an accident, a quick response is critical to lessening the effects of the injury.

I also recommend one (1) amendment. Title 21 Del.C. §4309 bars driving a vehicle with any “nontransparent material” on the rear window of a vehicle. The yellow dot could technically

violate that statute. The sponsors could consult DMV and consider the following options: 1) ensuring that the yellow dots will be “transparent”; 2) amending the new §9706 to clarify that the yellow dot is an authorized exception to §4309; or 3) amending §4309 to clarify that the yellow dot is an exception to the general ban. According to the October 10, 2010 Huntsville Times article, there is no uniform yellow dot (“each participating state has a different logo”). The article contains an Alabama logo which includes the following text: “fire and rescue, emergency medical services, senior groups, and law enforcement”. The SCPD comments should be promptly shared with policymakers; DPH; the DHSS policy analyst, Debbie Gottschalk; and the DMV.

### 13. H.B. No. 265 (Delaware Cancer Treatment Access Act)

This legislation was introduced on January 25, 2012. As of March 1, it remained in the House Economic Development/Banking/Insurance/Commerce Committee. The legislative Website earmarks the bill with an incomplete fiscal note.

For background, I am attaching a recent News Journal article and articles from other states. The articles describe the need for “parity” in cancer treatment by making drugs available in pill form available to patients at the same cost as traditional intravenous or injected anticancer treatment. The News Journal article recites as follows:

Cancer treatment is undergoing what (Dr. Stephen) Grubbs called a “revolution”. Grubbs, who helped draft the legislation, said traditional chemotherapies often also kill healthy cells since the drugs douse the body in chemicals meant to kill rapidly dividing cells. Newer drugs, often available in oral form only, target cellular pathways or proteins specific to cancer cells, or trigger the immune system to fight them, sparing patients from negative side effects such as hair loss.

(Rep.) Hudson said cancer patients can spend up to four hours at a time, one to three days a week, receiving IV anti-cancer medications, and they have to be driven to and from appointments because of the potential for nausea. Oral drugs allow patients to receive treatment at home and go to work or live life as usual.

According to the January 18, 2012 NJSpotlight article, the American Cancer Society offered similar commentary in support of New Jersey legislation signed by Governor Christie on January 17, 2012:

“Oral chemotherapy is truly the wave of the future in cancer care,” the American Cancer Society said in written testimony to the legislature. “Oral treatments offer patients distinct advantages over traditional intravenous chemotherapy, including the fact that they are targeted therapies which attack only the cancer cells, leaving healthy cells alone. There is no scientific or medical rationale for categorizing orally-administered drugs differently than IV drugs.”

The bill would require State-regulated health insurers with plans covering both prescriptions and major medical services to allow patients the option of “pill-based” therapy at no

greater cost than intravenous or injected therapy. The News Journal article recites that similar legislation has been enacted in D.C. and 15 other states.

I recommend a strong endorsement. I also recommend sharing the attached April 1, 2010 analysis of the fiscal impact of this type of legislation in Connecticut. Based on experience in other states, the analysis concluded that the legislation “would have no impact on the state budget”.

#### 14. S.B. No. 143 (Voting Amendments to Delaware Constitution)

This bill was introduced on June 16, 2011. As of March 1, 2012, it remained in the Senate Executive Committee.

The legislation is designed to achieve conformity with federal law, modernize language, and remove the reasons for which a person may vote by absentee ballot from the Constitution. Since it contemplates amending Delaware’s Constitution, it must be enacted by a 2/3 vote of the 146<sup>th</sup> and 147<sup>th</sup> General Assemblies.

I have the following observations.

First, federal law authorizes voting at age 18. The Delaware Constitution authorizes voting only at age 21.

Second, federal law disallows literacy tests and allows persons to vote who may be illiterate. See, e.g. 42 U.S.C. 1973aa. The Delaware Constitution requires a voter to “be able to read this Constitution in the English language”.

Third, the Delaware Constitution is somewhat prescriptive in authorizing absentee ballots. For example, it contemplates use of absentee ballots based on “sickness or physical disability” but omits any reference to absence due to “mental disability”. The bill would remove limitations and simply allow the General Assembly to enact laws covering qualifications for use of absentee ballots.

I recommend endorsement.

#### 15. H.B. No. 216 (Insurer Denial of Tests & Procedures)

This bill was introduced on June 29, 2011. As of March 1, 2012, it remained in the House Economic Development/Banking/Insurance/Commerce Committee.

For background, I am attaching several articles which describe highly-publicized denials by BC/BS of cardiac tests. An investigation resulted in release of a critical report in April, 2011 and a September, 2011 consent agreement between the Insurance Commissioner and BC/BS. Under the agreement, BC/BS committed to pay a \$325,000 penalty and underwrite the costs of system to guide the approval process for cardiac testing. BC/BS had earlier eliminated a system in which a screening provider had to repay BC/BS compensation if it failed to meet a 20% savings target.

The legislation, which was introduced prior to the settlement agreement, would require State-regulated insurers to be subject to reimbursement and damages sustained by delayed treatment

due to unreasonably denied coverage of tests and procedures. To obtain relief, the patient would be required to exhaust internal and external administrative appeals, pay for the test or procedure “out of pocket”, and prove that the test or procedure was medically necessary based on the results. Thus, the impact of the law is restrained. If the Insurance Commissioner determined that an insurer violated the statutory standards three (3) or more times within 36 months, the Commissioner would process the denials as an unfair practice.

Although the issue with cardiac testing appears to have been resolved, the bill has broader application to non-cardiac tests and procedures. Moreover, the requirement of exhaustion of administrative review remedies offers insurers considerable protection and opportunity for correction of errors.

I recommend endorsement of the concept of the bill.

#### 16. H.B. No. 211 (Vo-Tech Admission)

This bill was introduced on June 22, 2011. As of March 1, 2012, it remained in the House Education Committee.

Consistent with the attached articles, the impetus behind the bill is criticism from Sussex County districts that Sussex Vo-tech is “creaming”, i.e., not accepting an equitable share of students with lower academic scores or with discipline profiles. Sussex Vo-tech repudiated those allegations as untrue.

I presented the attached critique of this legislation for review at the July 14 meeting of the SCPD P&L Committee. At that time, the Committee opted to defer commentary pending GACEC solicitation of updated information from the Vo-tech Districts. The Vo-tech Districts provided requested information to the GACEC and presented their perspective at the January 17, 2012 GACEC meeting. The minutes and relevant materials are attached.

Sussex Vo-tech notes that it already conducts a lottery which does not differentiate based on special education versus special education status, discipline, or attendance. However, the applicant must have passing grades (70 or higher) in all subjects. Some students are exempt based on a parent employed full-time by the District or a sibling of a current student or graduate within 2 years. For the 2011-2012 school year, the District accepted 48% (36/75) of special education student applications but 60% (436/724) of non special education applications.

The PolyTech School District (Kent County) accepted 313 of 510 applications in 2012 with the following results: 10.86% (34/313) special education students and 89.13% (279/313) non special education students.

The NCC To-Tech District materials indicate that it had 13.5% special education enrollment for the 2011-12 school year.

My July, 2011 analysis of statewide 2010-2011 DOE enrollment data revealed that Vo-tech districts statewide generally had a smaller percentage of special education students than the overall

public school system average of 13.87%: NCC (11.09%); Kent (8.69%); and Sussex (8.88%).

Overall, it would appear that a strict lottery approach would statistically result in enrollment of more students with disabilities in Vo-Tech Districts. In Sussex, the requirement that a student be passing all subjects to enter the lottery could disproportionately affect students with disabilities who may struggle academically due to learning disabilities, low I.Q., depressed grades based on disability-related absenteeism, etc. I therefore recommend endorsement of the concept of the bill.

#### 17. H.B. No. 245 (Criminal Code Disability-related References)

This bill was introduced on January 25, 2012. It was reported out of the House Judiciary Committee on January 25. As of March 1, it awaited a House vote.

The legislation is similar to H.B. No. 214 enacted in 2011. That bill amended disability-related references in many civil statutes to delete pejorative language and adopt a “people-first” language. This bill is intended to effect similar amendments within the criminal code. Unfortunately, it is rife with problems.

Although the synopsis emphasizes the legislative intent to not change the substance of criminal statutes, the terminology adopted in the bill could easily result in harm to individuals with disabilities. For example, under the commonly used “plain meaning” doctrine of statutory interpretation, courts eschew resort to legislative history in favor of the plain and ordinary meaning of terms. In multiple instances, this bill adopts language which is manifestly narrower and less protective of individuals with disabilities.

First, the bill substitutes “profound intellectual developmental disorder” for the terms “mental retardation” (lines 349 and 367) and “serious mental retardation” (lines 341, 351, 355, 359, 361, 375). Consistent with the attachments, the term “profound” mental retardation/intellectual disability means an individual with an I.Q. below 20! For perspective, the categories of “mental retardation” are as follows: mild (I.Q. 50-69); moderate (I.Q. 35-49); severe (20-34); and profound (0-20). Within these categories of mental retardation/intellectual disability, the prevalence rates are as follows: mild (85%); moderate (10%); severe (3-4%); and profound (1-2%). See attachment. Therefore, the bill literally “condenses” the scope of references to “mental retardation” and “serious mental retardation” to cover only 1-2% of the population with mental retardation/intellectual disability. The bill “muddies the waters” further by adopting a definition of “profound intellectual developmental disorder” which covers the entire population of individuals with mental retardation/intellectual disability, i.e., those with I.Q.s under 70 (lines 375-381). I recommend substituting “intellectual developmental disorder” for “profound intellectual disorder” throughout the bill.

Second, the bill substitutes “serious mental disorder” for “mental defect” in the definition section (lines 46-47 and 58-59). The following definition is stricken:

(18) “Mental defect” means any condition of the brain or nervous system recognized as defective, as compared with an average or normal condition, by a substantial part of the



medical profession.

The following definition is substituted:

(24) “Serious mental disorder” means any condition of the brain or nervous system recognized as defective as compared with an average or normal condition, by a substantial part of the medical profession.

By inserting the term “serious” prior to disorder, the term is manifestly narrower than the current term. Moreover, it is inconsistent to require a mental defect or disorder to be “serious” while not requiring a mental illness to be “serious”. The definition of “mental illness” has no “serious” component:

(19) “Mental illness” means any condition of the brain or nervous system recognized as a mental disease by a substantial part of the medical profession.

I recommend substitution of “mental disorder” for “serious mental disorder” in the definition (lines 58-59) and seriatim (e.g. lines 74, 80, 81, 92, 99, 167, 170).

Third, line 152 contains a reference to “criminal mental illnesses”. This makes no sense. There are no “criminal mental illnesses”. I recommend deletion of the word “criminal”.

Fourth, the bill deletes the definition of “mental defect” (lines 46-47) while retaining references to “mental defect” (lines 167 and 170). This should be reassessed.

Fifth, the term “intellectual disabilities” should be substituted for the term “mental retardation” at line 480. Compare Title 16 Del.C. §1102(4).

I recommend sharing the above observations with policymakers, the Public Defender, ACLU, and DHSS Secretary.

## Attachments

8g:legreg/312bils  
F:pub/bjh/leg/2012p&l312bils