

MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Legislative & Regulatory Initiatives

Date: April 9, 2012

I am providing my analysis of thirteen (13) legislative and regulatory initiatives in anticipation of the April 12 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. DLTCRP Final Neighborhood Home Regulation [15 DE Reg. 1477 (April 1, 2012)]

The SCPD and GACEC submitted twenty-nine (29) comments on the proposed version of this regulation in January, 2012. The Division of Long-Term Care Residents Protection is now adopting a final regulation with many amendments prompted by the commentary. Since the Division did not address each comment individually, I am reproducing the commentary below followed by the change, if any, highlighted by italics.

1. In Section 2.0, the definition of “advocate” would include an individual who is “knowledgeable” about a resident but is an abuser or not well intentioned. Consider the following alternative: An advocate includes a guardian, legal representative, or knowledgeable person who seeks to promote the resident’s best interests”. The term “legal representative” would encompass an attorney, agent through power of attorney, or next of kin authorized to exercise rights pursuant to Title 16 Del.C. §§1121(34), 1122, and 2507.

*The Division adopted the recommended definition verbatim.*

2. In Section 2.0, definition of “co-mingling of funds”, the term “contacted provider” should be corrected. Consider substituting “contractual provider”.

*The correction was made.*

3. In Section 2.0, definition of “HRP”, substitute “device” for “devise”.

*The correction appears in the final regulation.*

4. In Section 2.0, definition of “incident”, consider expansion to cover elopement, attempted suicide, event prompting law enforcement referral, and use of seclusion or restraint in excess of certain time frames. Compare 16 DE Admin Code 3225, § 19.7 See also Title 16 Del.C. §5162(a) by analogy.

*Instead of amending the definition, the entire definition was stricken.*

5. In Section 2.0, definition of “individual”, substitute “identifies” for “identify”. On a conceptual level, the Division should also consider whether the definition is too narrow. In theory, there could be a licensed neighborhood home with individuals with developmental disabilities who do not receive services through DDDS. This comment would also apply to the definition of “service provider” which is limited to DDDS contractors.

*The definition was amended to address both concerns.*

6. In Section 2.0, definition of “neighborhood home”, first sentence, insert with “developmental disabilities” after the word “individuals”. Otherwise, the definition could literally encompass homes for individuals with mental illness or AIDS which are separately regulated by 16 DE Admin Code, Parts 3301 and 3305.

*The definition was amended to include a reference to “developmental disabilities”.*

7. In Section 2.0, definition of “PROBIS”, it would be preferable to include a reference to psychotropic medications. Review of such medications is the primary activity of PROBIS which is not apparent from the definition.

*The definition was not amended.*

8. In Section 2.0, definition of “service provider”, consider substituting “under contract” for “contracted”.

*The recommended amendment was adopted.*

9. In Section 3.0, it would be preferable to include a general requirement that the provider will comply with the Bill of Rights, Title 16 Del.C. §1121. See 16 DE Admin Code 3301, §4.9 (“All residents shall be afforded all protections and privileges contained in the Delaware Patients Bill of Rights”); and 16 DE Admin Code 3225, §14.1. The regulation requires “posting” of the Bill of Rights (§4.2.8.4), and compliance with DHSS policies (§4.7.3), but it lacks a section generally requiring compliance with the Bill of Rights.

*The section was not amended.*

10. Section 4.1.3.3 is inconsistent in referring to “services” and “service provider”. Since

§4.1.3 solely addresses a change in service provider, substitute “service provider” for “services”.

*The section is now §4.1.1.3. The text was not amended.*

11. Section 4.2.5 contains some “weak” and subjective references. Consider the following alternative: “Service providers are required to maintain and implement specific policies and procedures to facilitate individuals’ exercise of their rights and to protect the individual’s rights from either violation or restriction without due process.”

*The Division commented that the section was erroneously included in the proposed regulation. At 1478. The entire section was deleted.*

12. In Section 4.2.8.1, consider adding a reference to legal representative and advocate.

*The section is now §4.2.3.1. The amendment was added.*

13. Section 4.2.8.4 could be improved by requiring the posting to be in a “conspicuous” location as required by Title 16 Del.C. §1123. Otherwise, it could be posted in a closet or corner of the basement.

*The section is now §4.2.3.4. The amendment was added.*

14. Section 4.3.7.4 requires the residence to maintain only a three-day supply of medications. This is too short. A weather emergency could easily prevent access to a pharmacy for 3 days or a pharmacy could have exhausted its supply of a medication. A high percentage of DDS residential clients have seizure disorders and other life-threatening conditions being controlled by medications.

*This section is now §4.3.4.4. No change was made.*

15. Section 4.3.10 could be embellished. Compare 16 DE Admin Code 3225, §8.4. Parenthetically, the criminal statute requiring medications to be in the original container has been repealed. See H.B. No. 19, Section 55, enacted April 20, 2011. There is some “tension” between the regulatory requirement (§4.3.9.1) of medications being kept in original containers and the prevalent use of weekly dose containers.

*This section is now §4.3.6.1. It was amended to allow individuals approved for self-administration of medications to use weekly dose containers.*

16. In Section 4.5.1, the reference to the federal definition of assistive technology could be updated. See attached 29 U.S.C. §3002(3)(4)(5).

*The Division noted that this section was erroneously included in the proposed regulation. At 1478.*

*It was deleted.*

17. Section 4.5.4.3 could be improved. For example, it is common for DDDS clients to lose their eyeglasses or break them. Some clients are therefore provided with a set of glasses and a back-up set of glasses. It would therefore be preferable to substitute “periods of repair, replacement, cleaning or foreseeable loss.”

*The amendment was added.*

18. Section 4.6.4, second sentence, is a “weak” statement insofar as it states the Division’s “belief”. This is a regulation and it would be preferable to simply state the policy. The sentence could recite as follows: “Further, employment in the community should be the first service option considered for individuals.”

*The Division noted that the section was erroneously included in the proposed regulation. At 1478. It was deleted.*

19. In Section 4.6.5.2, delete the comma after “goals” and insert “and”.

*The section was deleted.*

20. In Section 4.6.6, substitute “an” for “a” after “documents”.

*The amendment was not made. The improper grammar remains.*

21. The timetables in Sections 4.6.6.4 and 4.6.6.5 (60 days to convene POC meeting after initiation of services and 90 days to implement POC after initiation of services” are too long. If they are not shortened, it would be preferable to amend the latter section as follows: “The POC is implemented within the earlier of 30 days from POC meeting or 90 days from initiation of services.” If a POC meeting were to be convened within 30 days of initiation of services, it should not take another 60 days to implement it.

*These sections are now §§4.6.1.5 and 4.6.1.6. The references were changed from “POC” to “ELP”. The time periods were not changed.*

22. Section 4.6.8.2, which addresses AT, merits endorsement.

*The section is now §4.6.3.2. No change was made apart from substituting “ELP” for “POC”.*

23. Section 4.6.10 is intended to promote community-based employment. However, it could be improved.

a. For example, §4.6.10.2 presumes that an individual is either working in the

community or unemployed. It ignores sheltered workshop employment. Consider adding “in a community setting” after “work” and “employment”.

*The section is now §4.6.5.2. The text was amended to add the reference to “in a community setting”.*

b. The requirement of a community based work assessment every 3 years (§4.6.10.3) could be improved by requiring such an assessment in connection with the initial POC. This could be addressed by adding a new subsection to 4.6.6. requiring a community-based work assessment as part of the overall assessment forming the basis for the initial POC.

*This section is now §4.6.5.3. No change was made apart from that described in the paragraph below.*

c. It would be preferable to amend §4.6.10.3 to refer to “at least every three years”. Otherwise a provider could argue that the regulation literally disallows more frequent assessments. Likewise, it would be preferable to authorize assessment based on reasonable request of the individual or legal representative. This would result in the following substitute sentence: “If an individual is not working in a community setting, a community based work assessment should be completed upon the individual’s reasonable request and at least every three years to determine if employment within the community would be a viable option for the individual.”

*This section is now §4.6.5.3. The requested substitute sentence was adopted with the exception of deleting “reasonable”.*

24. In §4.7.6.7, the requirement of a 72-hour supply of non-perishable food is too short. A weather emergency or other event could occur rendering a 3-day supply inadequate.

*This section is now §4.7.5.8. No change was made.*

25. In §4.8.10.4, it would be preferable to amend the reference to “adaptive equipment or assistive technology” since the latter term is used in §4.5 and is ostensibly more encompassing.

*This section is now §4.8.9.4. The requested amendment was adopted.*

26. In Section 6.4, it would be preferable to at least “phase in” a requirement that dishwashers include a “sanitizing cycle or capacity” whenever replaced or by a certain date (e.g. January 1, 2015) or whichever comes first. Cf. 16 DE Admin Code 3225, §17.6.3 (assisted living facilities must have sanitizing capability for dishes and utensils). See also attached articles.

*This section was amended. It now includes the following sentence: “The dishwasher must either have a sanitizing cycle or the home must use a dishwasher detergent with bleach.”*

27. Section 8.2 requires each sleeping room to have an outside window. This is a favorable feature but not uniformly required in other regulated settings. It does not seem to be required in

with mental illness (16 DE Admin Code 3305, §12.2.1. The requirement is not inherently objectionable but could limit capacity of some homes in the absence of a waiver.

*No change was made.*

28. Section 8.4 allows 75 square feet per person in 2-person bedrooms. The standard in assisted living and group homes for persons with mental illness is 80 square feet. See 16 DE Admin Code 3225, §17.5; and 16 DE Admin Code 3305, §12.2.2. The latter regulations also clarify that the room measurements do not include closets, wardrobes, alcoves, etc. It would be preferable to adopt an 80 square foot standard and clarify that it excludes closets, wardrobes, alcoves, etc.

*This section was amended. The following sentence was added: “Neighborhood homes licensed subsequent to the implementation of these regulations shall provide at least 80 square feet per person.”*

29. Section 9.5 uses the term “handicapped”. The reference should be modified.

*The comment applied to Section 9.4. The reference was changed.*

Since the regulation is final, and the Division adopted many amendments prompted by the commentary, I recommend a “thank you” communication.

## 2. DSS Prop. Child Care Subsidy Program Income Regulation [15 DE Reg. 1435 (April 1, 2012)]

The Division of Social Services proposes to delete a single regulation the content is covered by other regulations. At 1436. I compared the provisions in the deleted regulation to the balance of the regulations. I did not identify any concerns. The content of the deleted regulation is covered by the other regulations.

I recommend endorsement.

## 3. DOE Proposed Extracurricular Activities Regulation [15 DE Reg. 1404 (April 1, 2012)]

The Department of Education reviewed the existing regulation covering participation in extracurricular activities as part of its normal 5 year schedule. It determined that no changes were warranted is therefore proposing to “readopt” the current regulation.

In December, 2011, the GACEC forwarded the attached critique of DIAA standards. The DOE responded that it was reviewing the concerns. Since the regulation mentions the DIAA standards, it provides an opportunity to “resubmit” the critique. There is obviously some “tension” between the DOE “comment” in the regulation promoting flexibility in the context of students with disabilities versus the DIAA standards which are highly prescriptive.

I recommend that the Councils share the previously submitted concerns with the DIAA

standards as commentary on the regulation.

4. DPH Proposed Medical Marijuana Code Regulation [15 DE Reg. 1424 (April 1, 2012)]

The Division of Public Health proposes to adopt regulations implementing Delaware's law on medical use of marijuana enacted in May, 2011.

As background, the enacted enabling legislation (codified at Title 16 Del.C. Ch. 49A) requires the Department of Health and Social Services to issue implementing regulations. See Title 16 Del.C. §4923A. However, the viability of issuing regulations was ostensibly undermined by legal developments documented in the attached February, 2012 articles. Out of an abundance of caution, I sent an email inquiry to DHSS on March 30. In an April 2 response, the Department indicated that it is proceeding with implementation of the enabling legislation which does not violate U.S. DOJ guidance. The attached April 7, 2012 News Journal article provides further perspective on the proposed regulation.

I have the following observations.

First, the regulations, including definitions, generally track the statute.

Second, §5.3.6 authorizes a \$150 civil penalty if a patient or caregiver cardholder fails to report a change in address, physician, medical status, etc. This is consistent with Title 16 Del.C. §4912A. However, the regulation should include due process to contest the penalty. Compare §§8.2.5 (record review available to challenge suspension of registry identification card); and 8.4 (hearing available to challenge suspension or revocation of registry identification card).

Third, §8.5.3 recites that "(a)ll hearings held pursuant to this section shall be open to the public." Such hearings would typically involve confidential medical records and otherwise sensitive evidence. The statute explicitly contemplates that such information is confidential and protected, not "open to the public". See Title 16 Del.C. §4920A. For similar reasons, §8.14.4 is problematic since it makes a final hearing decision "public information" without redaction. . Cf. 16 DE Admin Code 5000, §5502 [DHSS hearing decisions can be published but in redacted form].

Fourth, in §8.8, substitute "bear" for "endure".

Fifth, §8.11 imposes the burden of proof on the patient or caregiver in all hearings. The traditional approach in administrative hearings is to impose the burden of proof on the "consumer" for denials of initial applications while imposing the burden of proof on the agency for terminations. The rationale is that there must be some change in circumstances to justify a termination. The agency should have the burden of showing the change in circumstances.

Sixth, the word "Secretary" should be capitalized in §§8.14.1, 8.14.2, and 8.14.3.

Seventh, §8.14.3 contemplates the hearing officer's issuance of a "recommended decision" which is subject to the Secretary's revision. Since the Secretary was not involved in the hearing, this approach makes little sense. The general DHSS approach is to authorize its hearing officers to issue a final decision. Compare 16 DE Admin Code 5000, §5304.5.

I recommend sharing the above observations with the Division.

5. DMMA Proposed. HCBS Waiver Regulation. [15 DE Reg. 1414 (April 1, 2012)]

The Division of Medicaid & Medical Assistance is updating its regulations to reflect the conversion of multiple HCBS waivers into the new Diamond State Health Plan Plus (DSHP+) Waiver effective April 1, 2012. The new Waiver will be known as "Long Term Care Community Services". The "Summary of Proposal" notes that the ABI, Assisted Living, and Elderly and Disabled Waivers were merged into a consolidated Elderly/Disabled Waiver in December, 2010. This consolidated E&D waiver and the AIDS/HIV waivers are now being discontinued in favor of the DSHP+ Waiver. The DDDS HCBS Waiver remains a separate program.

There are essentially two sets of changes: A. striking sections related to the superseded programs and substituting sections related to the new program; and B. increasing "the daily living needs allowance for DSHP+ waiver participants in the community to equal their total income, including income that is deposited in a Miller Trust. At 1415 and 1421, §20720.

I did not identify any significant deficiencies. I have the following technical observations on specific sections.

First, §20700.1, Par. 2, refers to "(o)nce an individual is placed in a residential facility". This is a somewhat outdated concept which demeans individual autonomy and choice. Moreover, a shared living residence (a/k/a foster home) is not commonly viewed as a "facility". Consider the following substitute: "(o)nce an individuals accepts a residential setting".

Second, in §20720, Par. 2, add an "s" to "circumstance" to make it plural.

Third, in §20720, Par. 3, change the reference to "...Assisted Living Facility will ~~make~~ submit their patient pay amount..."

I recommend endorsement subject to correction of the above minor concerns.

6. DMMA Prop. DSHP Plus Regulation [15 DE Reg. 1408 (April 1, 2012)]

The Division of Medicaid and Medical Assistance proposes to adopt some discrete regulatory changes to conform to the implementation of the DSHP+ initiative. The amendments appear to be "housekeeping" measures and I did not identify any significant concerns.

I recommend endorsement.

7. DMMA Prop. Estate Recovery & Managed Care Regulation [15 DE Reg. 1412 (April 1, 2012)]



The Division of Medicaid and Medical Assistance proposes to add a clause to the Medicaid State Plan.

As background, federal law requires DMMA to pursue estate recovery for at least some Medicaid expenditures for individuals age 55 or older receiving nursing home services, home and community-based services, and related hospital and prescription drug services. At 1413. Based on the attached Section 3810(A)(6) of the State Medicaid Manual, when states use a managed care system with a capitation rate, they must pursue recovery of the premium paid to the MCO on behalf of the covered beneficiary. Therefore, DMMA is incorporating the authorization to seek estate recovery of MCO capitation payments in the State Plan.

Since, the amendment is ostensibly required to conform to CMS standards, I recommend endorsement.

#### 8. DLTCRP Prop. LTC Discharge & Discharge Hearing Reg. [15 DE Reg. 1405 (April 1, 2012)]

In January, 2012, I prepared draft legislation which, *inter alia*, would require DHSS to issue regulations defining both the content of discharge/transfer notices from long-term care facilities and the hearing procedures authorized by Title 16 Del.C. §1121(18). The draft legislation was shared with DHSS in January. On March 9, DHSS forwarded its comments which included a request for removal of the section of the legislation requiring DHSS to issue the above regulations. Instead, DHSS promised to include proposed regulations in the April issue of the Register of Regulations. The published regulations conflict with the statute and leave much to be desired, prompting the following twenty-seven (27) comments.

1. Current Section 3.1 literally recites that the DLTCRP regulation “governs” all discharges from a licensed facility. Fifty-seven percent (57%) of Delaware nursing facility residents are funded by Medicaid. See attached excerpt from Mercer, “Promoting Community-Based Alternatives for Medicaid Long-Term Services and Supports for the Elderly and Individuals with Disabilities”. These individuals have a federal right to contest a discharge or transfer with protections not reflected in the proposed regulation. See 42 C.F.R. §431.201, definition of “Action”; and 42 C.F.R. §431.220(a)(3). DMMA is responsible for providing such hearings. See 42 C.F.R. §431.205. DHSS regulations specifically apply the hearing procedures codified at 16 DE Admin Code Part 5000 to nursing home notices and hearings. See 16 DE Admin Code 5001, Par. 2.C; 16 DE Admin Code 5200; and 16 DE Admin Code 5401, Par. 1. C.3. The DLTCRP omits any reference to such entitlements. As a consequence, nursing homes which rely on the DLTCRP regulation for discharge/transfer notices and procedures for Medicaid patients will violate federal law and residents will be affirmatively misled. For example, such patients have 90 days to request a hearing to contest a discharge. See 42 C.F.R. §431.221(d); and 16 DE Admin Code 5307C.2. Medicaid patients also have a right to be advised of the specific regulation(s) upon which the discharge is predicated [16 DE Admin Code 5000, definition of “adequate notice”]; a fair hearing summary [16 DE Admin Code 5312] and many other specific protections in 16 DE Admin Code Part 5000.

At an absolute minimum, the regulation should include a cross reference or note alerting the reader that proposed discharges and transfers of Medicaid-funded patients of licensed long-term care facilities are subject to 16 DE Admin Code Part 5000. The better approach would be adopt or incorporate the Part 5000 regulations as the standards for discharges and transfers from all licensed long-term care facilities. If desired, 16 DE Admin Code 5304 could be amended to include any supplemental provisions related to long-term care discharges and the definition of “DHSS” in Section 5000 could be amended to include DLTCRP in connection with discharges from long-term care facilities. There would then be a single set of standards to apply rather than one set of standards for Medicaid patients and one set of standards for non-Medicaid patients.<sup>1</sup>

2. Section 1.2 defines “discharge” as “movement of a patient or resident to a bed in a separately licensed facility”. This is unduly constrictive. It categorically presumes that all persons whose residency is terminated by a facility go to another licensed facility. To the contrary, involuntarily discharged residents, including those discharged for “nonpayment”, may go to an unlicensed setting, a homeless shelter, or “the street”. Under the proposed definition, the regulation would be completely inapplicable to such terminations of residency and a facility would not even have to provide “notice of discharge” to residents being “evicted” to “the street”.

3. The relevant statute, Title 16 Del.C. §1121(18), contemplates a right to notice and a hearing for either discharge or “transfer”. The regulation does not mention “transfer”. The term should either be included in the definition of “discharge” or included in a separate definition. It would be preferable to include the term “transfer” in the definition of “discharge” so all later references could continue to simply refer to “discharge” rather than “transfer or discharge”.

4. Section 1.4 merits revision. First, it defines as a “party” an entity which has not yet been joined as a party. This would literally result in the right of mere applicants for joinder to enjoy all rights enumerated in Section 4.0. Even if that were preferred, it is illogical to only include applicants seeking party status “as of right” while excluding applicants seeking party status in the discretion of the hearing officer. It would be preferable to simply delete “,or properly seeking and entitled as of right to be admitted as a party to the agency proceeding”. A person or agency can apply for intervention or party status and, if the application is granted, the person or agency then enjoys party status.

5. In §1.0, consider adding a definition of “resident” which includes a “patient”. Then, the rest of the sections can merely refer to “resident” and avoid many references to “patient or resident”.

6. In §2.1, first sentence, insert “written” between “30 days” and “notice” to reinforce the implication in the balance of the section that an oral notice would not suffice.

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<sup>1</sup>Apart from Medicaid-funded nursing home patients, residents of DDDS waiver-funded group homes, shared living/foster homes, IBSER placements, etc. facing discharge also have a right to a Medicaid hearing. See 16 DE Admin Code 5000, definition of “DHSS”; 16 DE Admin Code 2101, §5.0. Likewise, residents of assisted living facilities partially funded through the assisted living waiver may have a right to a Medicaid hearing to contest discharge, especially if based on a facility’s determination that it cannot provide adequate care despite waiver services.

7. Section 2.1 contemplates notice to the resident, the DLTCRP, and the Ombudsman. The notice should also be given to individuals and agencies qualifying under either Title 16 Del.C. §§1121(34) or 1122. This is not limited to situations in which the resident lacks competency. For example, if DDDS or APS places a client in a nursing home or group home, the provider should notify DDDS or APS of the planned termination. Likewise, the representative payee appointed by the Social Security Administration should receive notice.

8. Section 2.0 is deficient since it does not tell the recipient of the time period and method for filing an appeal. The notice should explicitly identify the time period (at least 30 days for non-Medicaid patients). Moreover, since §1121(18) does not require appeals to be in writing, “silence” in the notice may result in many telephonic appeals on the last day. Section 2.1.4 requires the discharge notice to include “a statement the patient or resident has the right to appeal the action” but omits any information describing how to appeal. This deficiency is then compounded by Section 3.1.1 which is very prescriptive in its requirements for submission of a request for hearing. The resident should be advised in the notice of the procedure to request a hearing. Compare 16 DE Admin Code 5300, §1.B.

9. Section 2.0 omits any reference to “the circumstances under which ‘assistance’ is continued if a hearing is requested.” Compare 16 DE Admin Code 5000, definition of “adequate notice”. The regulation is silent on whether the request for hearing “tolls” the discharge. Section 3.1.2 contemplates “tolling” of the discharge upon filing of a request for hearing but this should be disclosed in the notice to provide the resident with important information and “peace of mind”. In cases involving a resident returning from an acute care setting, it would also be preferable to disallow “filling” the resident’s bed during the pendency of proceedings.

10. Section 2.0 omits “the specific regulations supporting such action.” Compare 16 DE Admin Code 5000, definition of “adequate notice”. For example, if an assisted living facility proposed discharge based on its view that the resident has an “unstable” peg tube, it should cite 16 DE Admin Code 3225, Section 5.99. This is “basic” due process and required by the Third Circuit’s Ortiz v. Eichler decision.

11. For discharges of Medicaid patients, the notice would have to be detailed, i.e., allow the resident to tell from the notice alone the accuracy of the basis for discharge. Compare 16 DE Admin Code 5300, §2.D and Ortiz v. Eichler. Thus, in non-payment cases, the notice must include the calculations upon which the discharge is based. This should be clarified in §2.0.

12. Merely providing the mailing address of agencies in §§2.1.5 and 2.1.6 may hinder contact. Many individuals in long-term care facilities may lack the wherewithal to write a letter to the Ombudsman or DHSS divisions and the time to act is very limited. The phone numbers of the agencies should be included in the notice.

13. In §2.1.8, the term “phone number” was apparently omitted between “mailing address and” and “of the agency”. Compare §2.1.9.

14. In §2.1.9, the term “residents who are mentally ill” explicitly violates Title 29 Del.C. §608(b)(1)a. Consider substituting “residents with mental illness”.

15. Although Sections 2.1.8 and 2.1.9 are helpful, consider expansion. For example, CLASI’s elder law program (funded in part through DSAAPD Older Americans Act revenue) could represent elderly patients at no cost. Likewise, CLASI’s DLP represents individuals with disabilities apart from those with a mental illness or developmental disability (e.g. those with late onset disabilities such as M.S. or cancer). DSS standard notices (excerpt attached) provide information on sources of free or low cost legal services, i.e., CLASI. The DLTCRP could require a broader disclosure in Section 2.0.

16. Section 3.1.1 is defective in several major contexts. First, the scope of entities authorized to file an appeal is narrower than the statute. Compare Title 16 Del.C. §§1121(34) and 1122. Second, while the statute confers at least a 30 day time period to request a hearing, and Medicaid patients have at least a 90 day period to request a hearing, the third sentence effectively truncates the appeal period to 20 days! This is highly objectionable. Third, the last sentence requires the resident to identify the attorney or person who will represent the resident at the hearing as a categorical requirement (“the notice must also include”) in the request for hearing. This is also highly objectionable. A resident should be allowed to appeal even if he/she has not yet hired an attorney or representative.

17. Section 3.1.2 contemplates issuance of a notice to the facility by DHSS “that the patient or resident is not to be discharged during the time the appeal is underway.” It would be preferable to modify §3.1.1 to include a bar on discharge once the facility receives the notice of appeal. Otherwise, the facility could discharge prior to the DHSS 5-day notice and literally not violate any part of the regulation. Moreover, in a 2010 case, a facility “filled the only bed” during the pendency of a hearing in which a resident was trying to return from an acute care setting. In re Proposed Discharge - J.H. Jr (DHSS July 7, 2010)(Steinberg, H.O.). The proposed regulation does not address this scenario. The regulation should be amended to require a respondent facility to not fill at least 1 “bed” in the latter situation. Consider the following standard:

If the appeal (hearing request) is filed on behalf of a patient returning from transfer to an acute care facility, the facility shall refrain from filling one available opening during the pendency of proceedings.

18. The DSS hearing regulation [16 DE Admin Code 5406K; 16 DE Admin Code 5400, §1.C] authorizes the hearing officer to order an independent medical assessment. This could be a useful option to include in the DLTCRP regulation. For example, an indigent resident may not be able to afford a medical expert and a hearing officer might feel “hamstrung” if the only medical experts are presented by the facility.

19. Section 3.1.3 requires issuance of a decision within 60 days from the date of discharge. Section 3.1.4 authorizes continuances. At a minimum, the Division could consider amending §3.1.3, second sentence, as follows:

The impartial hearing officer shall conduct the hearing and, subject to §3.1.4.1, issue a

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decision within 60 days from the date of discharge.

Parenthetically, the time frame for issuance of a decision involving discharge of a Medicaid patient is 90 days and it would be preferable to adopt the same time frame. See 16 DE Admin Code 5500, §1.

20. Section 4.0 does not address the resident's right to review the facility's records pertaining to the resident, including financial records in cases involving discharge based on non-payment. Compare Title 16 Del.C. §1121(19) and 16 DE Admin Code 5403. The following provision could be added:

To examine all facility records pertaining to the resident in the possession, custody, or control of the facility.

21. Section 4.0 does not differentiate between rights accorded the resident versus the facility. Literally, this means a facility could request interpreters, the facility could withdraw a hearing request, and a corporate entity could proceed without a licensed attorney. Cf., Delaware Supreme Court Rule 72. It would be preferable to differentiate between rights pertaining to the resident from the rights pertaining to the facility. Parenthetically, there is an extraneous "/" in Section 4.2.

22. Section 6.0 omits an opening sentence or clause (e.g. "(t)he hearing officer will:") Compare 16 DE Admin Code 5406. Section 6.7 is a sentence in contrast to Sections 6.1 - 6.6. It should be converted to a clause for grammatical consistency. Consider the following alternatives:

- Issue a decision which shall have the effect of a final ruling by the Department.
- Issue a decision which shall be considered a final ruling by the Department.

23. In Section 6.1, the reference to "runs the hearing" is somewhat colloquial. Compare 16 DE Admin Code 5406 ("regulate the conduct of the hearing to ensure an orderly hearing in a fashion consistent with due process").

24. Sections 6.2 and 6.6 are redundant.

25. Section 6.0 omits multiple provisions in the comparable 16 DE Admin Code 5406.

26. In Section 7.0, insert "and persuasion" after "proof" to reinforce Section 5.1. Compare Title 14 Del.C. §3140.

27. Section 8.0 is a bit odd. DHSS publishes redacted copies of all of its fair hearing decisions on its Website at <http://dhss.delaware.gov/dhss/dmma/fairhearings.html> See attachment. Moreover, the decisions would be subject to a FOIA request.

I recommend sharing the above comments with the DLTCRP as well as the DHSS Secretary; Long-term Care Ombudsman; DSAAPD Director; and the DHSS Chief Policy Advisory,

Debbie Gottschalk. I also recommend promptly sharing the commentary with the AARP to facilitate its review and possible submission of conforming comments.

9. H.B. No. 275 (Veteran Employment State Tax Credit)

This bill was introduced on March 15, 2012. The bill passed the House unanimously on March 27, 2012. It was approved by the Senate Revenue and Taxation Committee on April 4 and awaits action by the full Senate.

As background, I am attaching a March 16, 2012 News Journal article and March 16, 2012 News Journal editorial endorsing the legislation.

The bill is patterned on similar legislation enacted in Illinois, California, Minnesota, and West Virginia. It would provide a state tax credit of 10% of gross wages of a “qualified veteran”. The credit would be available for up to 3 years and would be capped at \$1,500 annually. A “qualified veteran” is limited to persons who served in recent campaigns (Iraq; Afghanistan; Global War on Terror) as documented by receipt of a certain medal. There is a modest fiscal note accompanying the bill (\$20K in FY13; \$40K in FY14). The News Journal article indicates that there are 7,000 Iraq and Afghanistan war veterans in Delaware.

Consistent with the attached U.S. Bureau of Labor Statistics information, the unemployment rate for veterans with disabilities is higher than the unemployment rate for veterans without disabilities. Tom Brokew of NBC’s DATELINE highlighted the plight of an unemployed Iraqi war veteran (with diagnoses of PTSD, thyroid disorder, and orthopedic impairment) in a Sunday, March 25, 2012 program. The video can be accessed at <http://www.msnbc.msn.com/id/3032600/vp/46837934#46837934>. H.B. No. 275 would benefit veterans with and without disabilities.

I did not identify any technical concerns with the bill. I recommend a strong endorsement. Since this appears to be a “fast track” bill, the endorsement should be issued soon to have any effect.

10. H.B. No. 264 (Driver Education)

This bill was introduced on March 8, 2012. It was approved by the House Education Committee on March 14. It passed the House on March 22 and passed the Senate on April 5. As of April 9, it awaited the Governor’s signature.

As background, the current statute [Title 14 Del.C. §4125(a)(2)] authorizes students who “qualify as a 10<sup>th</sup> grader” to enroll in a driver education course. A Department of Education regulation [14 DE Admin Code 540, §1.1] only allows a student to enroll once in the course: “Delaware public school residents are entitled to free driver education one time only.”

The original bill would have created an exception to the “10<sup>th</sup> grader” standard by allowing students with an IEP to complete their driver education certification by age 21. However, the

attached House Education Committee report included the following observation: The committee found that there is no additional funding required to extend the age of completion because each student would only be able to take the course in school one time.” H.A. No. 1 was added to the bill to allow a student with an IEP to take the course on more than one occasion: “Pursuant to Department of Education regulation, the student may be authorized to subsequently enroll in another driver education course if the student fails the driver education course during the regular school year.” The bill which passed the House incorporated this provision.

The bill could have been improved.

First, under State law [Title 14 Del.C. §3101(1)], special education eligibility does not end at age 21. It terminates at “the end of the school year in which the person attains the age of 21” Thus, it would have been preferable to adopt that standard rather than “until age 21”.

Second, as recognized by DOE regulation [14 DE Admin Code 540, §1.3], students with disabilities covered by Section 504 of the Rehabilitation Act or the ADA are entitled to reasonable accommodation in policies which could include enrollment in driver education more than once and through age 21. The bill could have explicitly covered these students as well.

Since the bill has already passed the House and Senate, I recommend no further action.

#### 11. H.B. No. 268 (School Bullying)

This bill was introduced on March 8, 2012. As of April 9, it remained in the House Education Committee.

As background, I attach an informative article from the Winter, 2012 issue of the PACER Center’s newsletter. It notes that children with disabilities are at increased risk for bullying. Such conduct may qualify as disability harassment in violation of federal civil rights laws. The article describes a variety of strategies to protect students disabilities from bullying, including “shadowing” victims, identifying an adult in the school to whom bullying can be reported, and allowing the student to leave class early to avoid hallway incidents.

The impetus behind the Delaware legislation is discussed in the attached December 16, 2011 News Journal article and the March 5, 2012 News Journal editorial endorsing H.B. No. 268. I am also attaching an April 9, 2012 News Journal article describing State efforts to address cyberbullying. Although current Title 14 Del.C. §4112D(b)(2)k requires districts and charter schools to report bullying incidents to the DOE within 5 working days, compliance is not uniform. For example, the December 16 article includes a critical observation from Attorney General Biden that one NCC district reported zero incidents of bullying in the 2010-2011 school year.

The bill would amend the current State law as follows: 1) requiring reporting of all reported bullying incidents to the DOE, whether substantiated or not (lines 47-48); 2) advertising the phone number of the DOJ School Ombudsman (lines 60-62, 71); 3) requiring the DOE to conduct random

audits of school compliance with information collection and reporting standards (lines 78-79); and 4) requiring the DOE to publish an annual report with audit findings (line 79).

I did not identify any concerns with the proposed changes to the existing statute. I recommend endorsement.

12. H.B. No. 261 (Utility Terminations)

On March 26, I shared the commentary below with the SCPD, DDC, and GACEC with a courtesy copy to DHSS representatives. The commentary was shared with DHSS, AARP, key legislators, and others. On April 3, I also prepared the amendment reproduced below to be shared with the prime sponsors and House Committee. DHSS responded with an email confirming no objection to the amendment. As of April 9, the bill remained in committee. I recommend that the Committee endorse the amendment. I also recommend that the views of the prime sponsors on the amendment be solicited.

MEMORANDUM

To: Kyle Hodges, SCPD

From: Brian Hartman

Re: H.B. No. 261

Date: March 26, 2012

I am providing the following critique of the above legislation through this memo. Given time constraints, the commentary should be considered preliminary and non-exhaustive.

This bill was introduced on March 8, 2012. As of March 26, it remained in the House Transportation, Land Use, and Infrastructure Committee. It is scheduled to heard in the Committee on March 28. It's principal effect will be to weaken protections available to individuals with disabilities from utility terminations. Background is provided in the attached March 5, 2012 press release.

Under the current statute [Title 26 Del.C. §117(d)], utilities supplying gas, electric and water are prohibited from terminating services to premises if “any occupant of any dwelling unit shall be so ill that the termination of such sale or service shall adversely affect his health or recovery, which has been so certified by a signed statement from any duly licensed physician.” Such a certification delays “shut-offs” for 120 days and is renewable. In practice, I am advised that Delmarva Power routinely violates the statute by disallowing signed physician certifications which are not submitted on Delmarva’s form. Neither the statute nor any PSC regulation requires the certification to be on the Delmarva form. Moreover, I am advised that Delmarva routinely disallows certifications if there are any minor or technical omissions in the form submitted by the physician.



The press release notes that 955 Delmarva customers in Delaware participate in the medical certification program and that 75% are “delinquent”, resulting in a total of \$3.6 million in outstanding accounts. The press release does not specify how much of the \$3.6 million is attributable to service charges versus late fees and non-service charges. The attached PSC regulation authorizes Delmarva to impose an unrestrained 18% annualized fee (1.5%/month) on late payments. Moreover, the attached PSC regulation disallows customer enrollment in a budget billing plan (“which allows Customers to levelize their monthly bills”) if there is any delinquent outstanding balance.

I have the following observations on the text and effects of the bill.

First, the current statute authorizes deferral of termination based on the following standard: “any occupant ...shall be so ill that the termination of such sale or service shall adversely affect his health or recovery.” The bill proposes to allow shut-offs unless the occupant would either die or be immediately hospitalized without utility services: “termination will prevent the use of life-support equipment or cause loss of life or immediate hospitalization”. This is a draconian standard. It is far more restrictive than standards in Delaware’s sister states:

- Pennsylvania: A public utility may not terminate service, or refuse to restore service, to a premises when a licensed physician or nurse practitioner has certified that the customer or applicant seeking restoration of services under §56.191 (relating to payment and timing) or a member of the customer’s or applicant’s household is seriously ill or afflicted with a medical condition that will be aggravated by cessation of services.

52 Pa. Code §56.111 [emphasis supplied]

- Maryland: Electric or gas service, or both, may not be terminated for an initial period of up to 30 days beyond the scheduled day of service termination when the termination will aggravate an existing serious illness or prevent the use of life-support equipment of any occupant of the premises subject to the provisions of this regulation.

COMAR 20.31.03.01 [emphasis supplied]

- New Jersey: Discontinuance of residential service for nonpayment is prohibited for up to 60 days if a medical emergency exists within the residential premises, which would be aggravated by a discontinuance of service.

Title 14 N.J. Admin Code, Ch. 3, Subchapter 3A, 14:3-3A.2 [emphasis supplied]

Under the “death or immediate hospitalization” standard espoused in the Delaware bill, reliance on a suction machine, apnea monitor, hemodialysis machine, respirator, refrigerated medication, ceiling lift, or nebulizer may not qualify. It might take a day or a few days without utility service before the person is hospitalized or dies.

In fact, this bill could easily result in the deaths of customers with disabilities. Much-

Second, this bill should have a fiscal note. If technology dependent individuals with disabilities are forced to leave their homes, a significant percentage will predictably require emergency housing. Given exacerbation of their medical condition, some may require nursing home placement. Since the affected population would be comprised primarily of low income individuals unable to pay their full utility bills, a high percentage will be Medicaid beneficiaries. Consistent with the attachment, Delaware Medicaid pays the costs for 57% of all nursing home residents. For perspective, if only 4% of the 955 program participants (38 individuals) end up in nursing homes, at an average cost of \$80,000, the result is \$3.040 million in nursing home costs.

Third, Delmarva has an alternative to termination of electric. The attached PSC regulation offers the following option:

#### D. Load Limiting Devices

At the Company's option, in lieu of disconnection of Residential Customers for non-payment pursuant to above Sections XV-2-2(b) or (d), the Company may install a load limiting device that restricts the amount of power flow to the Customer, pursuant to an approved program on file with the Delaware Public Service Commission.

Fourth, the bill adds another restriction on eligibility, i.e., "the occupant of the premises makes a good faith effort to make payments towards the utility service being provided" (lines 10-11). There is no definition of "good faith effort" and Delmarva has a vested financial interest in interpreting this subjective term restrictively. Moreover, the "occupant" may be a child or household member who is not the Delmarva customer. It makes no sense to assess "good faith" payment efforts of a child or non-customer.

Fifth, the restrictions in the bill also apply to termination of water service (line 8). Obviously, cutting off water may not cause "immediate hospitalization". It may take a day or two days of not being able to use a toilet or drink to become bloated with toxins or dehydrated. Delmarva is not a water provider and the justification for adding restrictions on access to water are not apparent.

Sixth, the bill adds an authorization for the utility or customer to seek PSC review and "Commission adjudication" (lines 12-14). The PSC process, which includes motions, discovery and briefing, is complex. See [http://dep.sc.delaware.gov/legal/rules\\_prac.pdf](http://dep.sc.delaware.gov/legal/rules_prac.pdf). Obviously, individuals who lack the funds to pay their utility bill will be unable to hire an attorney to represent them in the administrative hearing process. In contrast, Delmarva is familiar with the PSC and has attorneys for representation. While offering PSC review to the customer may provide some limited protection, the viability of customer resort to the process would be undermined by its complexity and unequal access to attorney representation.

For the above reasons, the SCPD may wish to oppose the bill.

Attachments

(4/3/12 Hartman Draft)

SPONSOR:

HOUSE OF REPRESENTATIVES  
146<sup>th</sup> GENERAL ASSEMBLY

H.A. NO. 1

TO

H.B. NO. 261

AMEND House Bill No. 261 by deleting lines 1 through 14 and by substituting in lieu thereof the following:

(d) In no event shall such termination occur if any occupant of any dwelling unit shall be so ill that the termination of such sale or service shall adversely affect his health or recovery, which has been so certified by a signed statement from a duly licensed physician, physician assistant or advanced nurse practitioner of this State or any accredited Christian Science Practitioner and received by any employee or officer of such person engaging in the distribution or sale of gas, water or electricity. Signed statements from a licensed physician, physician assistant or advanced practice nurse or accredited Christian Science practitioner obtained pursuant to this section are effective for 120 days. Signed statements may be renewed by means of a new signed statement to prevent termination only if a customer makes a good faith effort to make payments towards the utility service being provided. The Delaware Public Service Commission, after consultation and approval by the Secretary of the Department of Health and Social Services, shall promulgate regulations defining “good faith effort”, requiring advance notice to any known agency case manager or coordinator of occupants in the affected dwelling unit, and establishing a rebuttable presumption that payment of 10% of countable household income towards the aggregate of gas, water, and electricity is a “good faith effort”. A utility or customer may petition the Delaware Public Service Commission for review of any dispute hereunder. While such dispute is pending, a utility shall continue to provide utility service to the customer until a final Commission adjudication on the petition is issued.

SYNOPSIS

This amendment preserves existing law on medical eligibility to defer utility termination while requiring any renewal to be accompanied by a “good faith effort” to make payments. The

Delaware Public Service Commission shall issue implementing regulations with the consultation and approval of the Department of Health and Social Services which has expertise in developing financial eligibility standards for individuals with disabilities.

8g:legreg/hb261ha1

### 13. Draft Employment First Legislation

Rep. Heffernan briefed the SCPD on this legislation at the SCPD's March 19 meeting. Rep. Heffernan, forwarded an updated draft of this bill to the Councils on April 3. I submitted a critique to the Councils and sponsor on April 4. Kyle and I also met with Rep. Heffernan on April 4 and shared an additional suggested amendment, i.e., to change the SCPD's enabling statute to authorize it to serve as the administering agency for the proposed Employment First Oversight Commission. The resulting April 5 version of the bill (attached) incorporates seven (7) amendments prompted by the critique.

The legislation establishes the "Employment First Act" to promote opportunities for persons with disabilities to acquire competitive work in integrated settings. All state agencies would be expected to prioritize and implement this public policy when offering services to persons with disabilities. State agencies would be encouraged to adopt measurable goals and objectives to promote assessment of progress. An Employment First Oversight Commission would be established under the SCPD. The Commission would facilitate implementation of the Act, aggregate data, and include results in the SCPD's annual report.

I recommend a strong endorsement.

### Attachments

8g:legreg/412bils  
F:pub/bjh/legis/2012p&l/412bils