

## MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Legislative and Regulatory Initiatives

Date: May 8, 2012

I am providing my analysis of eighteen (18) legislative and regulatory initiatives in anticipation of the May 10 meeting. Given time constraints, the commentary should be considered preliminary and non-exhaustive.

1. DMMA Final Provider Screening & Enrollment Reg. [15 DE Reg. 1609 (May 1, 2012)]

The SCPD and GACEC commented on the proposed version of this regulation in March, 2012. The Councils endorsed the initiative with no suggested changes since it was designed to implement a new CMS regulations which became effective March 25, 2012. The Division of Medicaid & Medical Assistance has now acknowledged the endorsements and adopted a final regulation which conforms to the proposed version.

I recommend no further action.

2. DMMA Final Disproportionate Share Hospital Regulation [15 DE Reg. 1613 (May 1, 2012)]

The SCPD and GACEC commented on the proposed version of this regulation in March. A copy of the March 23 GACEC letter is attached for facilitated reference. The Councils endorsed the concept of the initiative. The Councils also observed that the standards appeared to favor acute care hospitals and DPC as juxtaposed to private psychiatric hospitals. The Councils surmised that this might be based on the “for profit” status of private psychiatric hospitals in Delaware.

The Division of Medicaid and Medical Assistance has now acknowledged the commentary and adopted a final regulation with no further changes. In its response to the Councils’ commentary, the Division confirms that the Councils’ impression is accurate, i.e., the standards are designed to favor non-profit acute care hospitals and the DPC which have historically served more lower income patients than private, for-profit psychiatric hospitals. At 1615.

I recommend no further action.

3. DSS Final Food Supp. Program Drug Disqualification Reg. [15 DE Reg. 1616 (May 1, 2012)]

The SCPD and GACEC commented on the proposed version of this regulation in March, 2012. A copy of the March 27, 2012 SCPD memo is attached for facilitated reference. The Councils endorsed the initiative since it was designed to conform to S.B. No. 12 which was enacted in 2011. The Division of Social Services has now acknowledged the endorsements and adopted a final regulation with no further changes.

I recommend no further action.

4. DLTCRP Final IBSER Regulation [15 DE Reg. 1603 (May 1, 2012)]

The SCPD and GACEC commented on the initial proposed regulation in November, 2011. The Division of Long-term Care Residents Protection then issued a new proposed regulation in March, 2012. The Councils submitted thirty-two (32) comments on the March version. A copy of the March 27, 2012 memo from the SCPD is attached for facilitated reference. The DLTCRP is now adopting a final regulation which incorporates many revisions based on the commentary. My analysis will follow the comments seriatim.

1. The Councils summarized many changes in the March version which incorporated suggestions from the Councils' November commentary. The Division responded "(n)o comment required".

2. The Councils recommended the insertion of a more comprehensive "purpose" section. The Division agreed and added a few sentences.

3. The Councils objected to an "overbroad" "medical device" exception from the definition of "mechanical restraint". The Division agreed and inserted the Councils' recommended references to a physical or occupational therapist.

4. The Councils objected to a provision reciting that any equipment used to deter SIBS is per se not a "restraint". It would therefore be exempt from HRC and BMC review. The Division did not correct this aspect of the regulation.

5. The Councils recommended some changes to the definition of "physical restraint". The Division disagreed and effected no amendments.

6. The Councils noted that the regulation includes a definition of "seclusion" but no section addressing use or limitations on use of seclusion. The Councils also stressed that the licensing statute bars "involuntary seclusion". The Division responded that the definition is intended to "capture the prohibition against isolating an individual." Therefore, the Division's intent is ostensibly to bar seclusion consistent with the statute. However, there is still no operative reference to seclusion within the body of the regulation which could result in confusion on the permissible use of seclusion.

7. The Councils noted that the definition of "Specialized Behavior Support Plan" was

defective in the context of restraint. The Division agreed and amended the definition.

8. The Councils recommended a grammatical change to §5.5. The Division amended the section.

9. The Councils recommended incorporation of a PM 46 reference similar to that contained in the Division's neighborhood home regulations. The Division responded that the PM 46 policy would apply to an IBSER subject to contract with DHSS. No change was made.

10. The Councils shared their concern that "grandfathering" 10-16 bed facilities may violate the ADA. The Division responded that the "grandfathering" was a compromise to enable the viability of the current operation.

11. The Councils recommended the addition of "legal representative" to §6.2.2. The Division agreed and added the term.

12. The Councils reiterated a concern that the square footage of "grandfathered" bedrooms was less than that in comparable facilities. The Division responded that the "grandfathering" was a compromise to enable the viability of the current operation.

13. The Councils characterized an authorization for adults to sleep in bunk beds as not age-appropriate. The Division responded that the "grandfathering" was a compromise to enable the viability of the current operation. This response is not "apt" since the authorization to use bunk beds is not limited to existing facilities. It applies to all IBSER-licensed facilities, even those prospectively licensed.

14. The Councils recommended consultation with a dental expert to assess the merits of requiring access to a fluoride rinse for facilities using well water. The Division responded that 3 of 13 existing residential IBSER sites use well water. The Division noted that DDDS clients receive annual dental exams which could include recommendations for fluoride access on an individual basis.

15. The Councils recommended adoption of an emergency store of food and water similar to that contained in its neighborhood home regulation. The Division declined to effect an amendment based on the rationale that "(b)est practices governing disaster preparedness are currently under consideration for all licensed facilities."

16. The Councils recommended reconsideration of the minimum age standards for direct care workers. The Division effected no change.

17. The Councils recommended substitution of "resident" for "patient" in §14.5.2. The Division agreed and changed the reference.

18. The Councils questioned the HRC membership standards. The Division did not

change the standards but did opine that a recent facility retiree would not be considered an external HRC member.

19. The Councils questioned a reference to the licensee's clinical director. The Division amended the section to delete the reference.

20. The Councils recommended adding an explicit reference to presentation of data to the BMC. The Division agreed and added a conforming reference.

21. The Councils recommended addition of the term "contractor" to §19.2. The Division agreed and inserted the term.

22. The Councils objected to an authorization to employ mechanical restraint based on the following standard: "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." The Division curtailed the breadth of the authorization by substituting the following standard: "The resident is exhibiting a problem behavior that is so severe that it poses an imminent risk of serious bodily injury to self or others."

23. The Councils questioned a reference to an undefined "SPTeam". The reference was deleted.

24. The Councils recommended addition of a section requiring the maintenance of any video recording of an episode of restraint. The Division responded that it is "developing a policy which will govern the use of video monitoring in all licensed facilities."

25. The Councils questioned the lack of specificity in a section requiring "clinical review and approval for interventions longer than 15 minutes." The Division amended the reference to require the review to be conducted by the facility CEO or designee.

26. The Councils shared concerns pertaining to a section contemplating clinical review of restraints lasting less than 15 minutes. The Division edited the section to require the review to be conducted by the facility CEO or designee.

27. The Councils recommended the addition of the following limit on use of aversive techniques: "Consistent with 34 C.F.R. §§300.2 ( c) and 300.146, use of restraint or aversive techniques on adult IDEA-funded residents or students which violate applicable law or regulation of the public IDEA funding agency." The Division agreed and inserted the provision verbatim.

28. The Councils recommended an amendment to the consent standards for psychotropic medications. The Division agreed and revised the section.

29. The Councils recommended amendments to the laundry standards to deter the spread

of diseases. The Division agreed and inserted choline and temperature standards.

30. The Councils recommended insertion of a reference to video records of incidents. The Division effected no change, commenting that “DHSS is developing a policy which will govern the use of video monitoring in all licensed facilities.”

31. The Councils identified an ostensible inconsistency in approach to physical versus emotional abuse. The Division effected no amendment and provided its rationale for the difference in approach.

32. The Councils questioned subjective standards in the context of reporting medication errors. The Division effected no amendments based on its view that the standards are objective.

Since the regulation is final, and the Division effected amendments based on approximately sixteen (16) of thirty-two (32) comments, I recommend issuing a “thank-you” communication.

5. DOE Final Teacher Appraisal Regulation [15 DE Reg. 1586 (May 1, 2012)]

I submitted a lengthy critique of the proposed version of this regulation to the Councils in March, 2012. Given the minor effect of the initiative, I recommended taking no position on the regulation. The SCPD and GACEC adopted that approach and did not issue comments. No one else commented on the regulation and the Department of Education has now adopted a final regulation which conforms to the proposed version.

I recommend no further action.

6. DOE Final Administrator Appraisal Regulation [15 DE Reg. 1596 (May 1, 2012)]

The SCPD and GACEC commented on the proposed version of this regulation in March, 2012. A copy of the March 27, 2012 SCPD memo is attached for facilitated reference. The Councils endorsed the initiative since it would enhance administrator accountability. The Department of Education has now acknowledged the endorsements and adopted a final regulation with no further changes.

I recommend no further action.

7. DOE Final Specialist Appraisal Regulation [15 DE Reg. 1595 (May 1, 2012)]

The SCPD and GACEC commented on the proposed version of this regulation in March, 2012. A copy of the March 27, 2012 SCPD memo is attached for facilitated reference. The Councils endorsed the amendments while reiterating an observation shared with the Department in commentary on the October, 2011 version of the regulation, i.e., the qualifications for achievement of both a “needs improvement” and “ineffective” rating are “euphemistic and overly generous”. The Department of Education has now acknowledged the comments and

adopted a final regulation with no further changes.

I recommend no further action.

8. DOE Final Professional Development Standards Regulation [15 DE Reg. 1599 (May 1, 2012)]

The SCPD and GACEC commented on the proposed version of this regulation in February, 2012. A copy of the February 15, 2012 GACEC letter is attached for facilitated reference.

First, the Councils endorsed certain standards within the regulation.

Second, the Councils recommended substituting “Council” for “Counsel” in §1.1. The Department agreed and effected the amendment.

Third, the Councils suggested three (3) grammatical changes in §1.3. The DOE agreed and effected the changes.

Fourth, the Councils suggested a grammatical change in §5.4. No change was made.

Fifth, the Councils suggested a grammatical change in §6.2. No change was made.

Sixth, the Councils criticized references to “increases results for all students” since the results could be “good” or “bad”. The Councils recommended substituting “enhanced student performance” or “improved student performance results”. No change was made.

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

9. DOE Prop. Data Governance Regulation [15 DE Reg. 1536 (May 1, 2012)]

This regulation is intended to implement Title 14 Del.C. §122(b)(25) which was added to the Code upon enactment of H.B. No. 213 in 2011. The statute requires the Department of Education, to issue regulations in collaboration with the P-20 Council, Interagency Resource Management Committee (IRMC) and State Board of Education covering the collection, use, maintenance, disclosure and sharing of educational records and information. The regulation focuses on data for research.

I have the following observations.

First, in §2.0, the definition of “educational record” is limited to agencies covered by FERPA, the IDEA and similar federal and State privacy and confidentiality laws. The DOE should consider whether this will omit some private schools. FERPA only covers schools receiving federal funds. See 34 C.F.R. 99.1. The IDEA generally covers only public schools and would not cover institutions of higher education. The definition might omit private elementary, secondary, post-secondary, and trade schools which do not receive federal funds but

may be subject to DOE regulation. Cf. Title 14 Del.C. §122(b)(8) and Chapter 85.

Second, §4.3.1 would literally categorically limit a school, school district, or postsecondary institution from conducting research in contexts other than “improving instruction; developing, validating, or administering predictive tests; or administering student aid programs.” This could be problematic. A school or college may wish to conduct an assessment of diversity, compliance with civil rights laws, transportation, interest in sports teams or extracurricular activities, college housing, etc. The regulation should not be so rigid as to disallow such research.

I recommend a general endorsement subject to consideration of the above concerns.

10. DMMA Proposed Medicaid State Plan Amendments [15 DE Reg. 1548 (May 1, 2012)]

The Division of Medicaid & Medical Assistance proposes to adopt two (2) discrete amendments to its Medicaid State Plan. The Summary of Proposal recites that the changes are being prompted by CMS commentary noting that the existing sections contain outdated standards. DMMA emphasizes that “(n)o one will lose eligibility as a result of this amendment”. At 1549.

Since the proposed changes are being prompted by CMS and revise outdated standards, I recommend endorsement.

11. DSS Prop. Child Care Subsidy Program Definitions Reg. [15 DE Reg. 1551 (May 1, 2012)]

The Division of Social Services proposes to amend its definitions used in its Child Care Subsidy Program. The Summary of Proposed Changes section recites that the rationale for the amendments is twofold: 1) federal prompting to add a definition of “children in families with very low income”; and 2) the desire to reformat and alphabetize the existing list of definitions.

I have the following observations.

First, the new definition of “children from low income families” is acceptable. At 1557. It adopts a “200% of the Federal Poverty Limit” standard which mirrors the existing standard reflected in the definition of “income limit”. At 1554.

Second, in the definition of “Child”, I recommend the following amendment: “...or are in need of protective services.”

Third, in the definition of “Child Care Centers, 41”, amend the example to read as follows: “(Example: One child is a citizen and one is not. The citizen child is a 41).” This would then be identical to the superseded version. At 1553.

Fourth, in the definition of “Child Care Certificate”, second sentence, substitute “parents who wish” for “a parent who wishes” since the following pronoun (“their”) is plural.

Fifth, in the definition of “Educational Program”, the semicolons are omitted and the word “or” is omitted after Par. “4”. Compare the current definition. At 1553-1554.

Sixth, in the definition of “Physical or Mental Incapacity”, DSS deleted the term “dysfunctional”. Compare the existing definition. At 1555. This conforms to Title 29 Del.C. §608 and merits endorsement.

I recommend endorsement subject to adopting the above technical corrections.

## 12. S.B. No. 178 (Agency Public Hearings)

This bill was introduced on March 22, 2012. It was approved by the Senate Judiciary Committee on May 1 and awaits action by the full Senate. As of May 8, it was on the “ready list” for Senate action. An advance copy of this critique of the bill was shared with the SCPD on May 3 resulting in the attached May 3 memo to the prime sponsor, Rep. Booth.

As background, the State Administrative Procedures Act (APA) contains standards for public hearings conducted by agencies in connection with proposed regulations. As the synopsis recites, S.B. No. 178 is intended to address two (2) aspects of this process.

First, if a hearing notice identifies a specific starting time and ending time for a hearing, the agency would be required to hold the hearing open until the advertised ending time. In practice, many public hearings draw no or few presenters. Therefore, agency personnel may be inclined to close a hearing if either no one appears at the beginning of the hearing or presentations by all participants have been made. It is possible that the public could be misled if a hearing notice provides a starting and ending time and a hearing adjourns early. For example, a presenter could appear at 7:30 for a hearing scheduled for 6:30-8:30 only to discover that the hearing has adjourned. If this legislation is enacted, I suspect agencies will simply adopt a hearing notice which includes a starting time and recites that the hearing will conclude the earlier of a specific ending time or conclusion of presentations by all persons in attendance. The public would then at least be on notice that appearance at the advertised time of hearing onset would be prudent.

Second, the APA currently requires a minimum 30-day public comment period. The bill would supplement this standard by requiring the comment period to extend to at least 15 days after the last public hearing. This change has some merit. For example, if an agency convened a hearing on the 29<sup>th</sup> or 30<sup>th</sup> day of a comment period, and presentations identified issues or concerns prompting either further research or analysis, there would be scant time to present comments by the 30-day deadline. Moreover, as a practical matter, many agencies cannot submit comments without a vote from their board or executive committee. This process may require a few days after a hearing to complete. At first glance, it appeared that the burden on the agency would be minimal since it could schedule the hearing(s) during the first 15 days of the comment period with no effect on the overall 30-day public comment period. However, there is a “glitch”. Title 29 Del.C. §10115 imposes a 20-day prior notice for any public hearing. Thus,



if an agency contemporaneously published a proposed regulation and hearing notice on May 1, the hearing could not occur until May 21, and the comment period would extend to June 4. The sponsors of S.B. No. 178 could consider a few options:

A. If the 20-day prior notice period were shortened to a 14-day notice period, a public hearing could occur on May 15 or 16 with no effect on the 30-day comment period.

B. If the proposed “15-day after final hearing” comment period were shortened to a 7-day period, a hearing could be convened on May 21-24 with no effect on the 30-day comment period.

C. If the 20-day notice period were shortened to a 15-day notice period AND the proposed “post-hearing” comment period were shortened from 15 days to 10 days, the hearing could be convened on May 16 -21 with no effect on the 30-day comment period.

Since some agencies convene a hearing in each county on separate dates, Options B and C may provide the best balance of agency flexibility and adequate time for public comment.

Given the above observations, I recommend endorsement of the concept of the legislation subject to consideration of potential amendments.

### 13. H.B. No. 299 (CPR Training)

This bill was introduced on April 4, 2012. As of May 8, it is scheduled to heard in the Health and Human Development Committee on May 9. I provided an advance critique with alternate versions of an amendment to the DDC on May 4. The DDC received a May 4 response indicating that the bill will include a conforming amendment.

The rationale for the legislation is outlined in the “Whereas” clauses compiled at lines 1-10. In nutshell, 80% of cardiac arrests occur at home, effective intervention can double or triple the victim’s chance of survival, and hands-only CPR has been proven to be as effective as CPR with breaths.

Beginning with the class of 2013, the bill would require all public and private schools to provide CPR training and require a student to participate as a condition of receipt of a diploma. Beginning with the class of 2015, the CPR training program would be required to address both psychomotor skills necessary to perform CPR and the use of an automated external defibrillator.

The DDC solicited technical assistance on May 4 given the potential impact of the bill in reducing graduation rates for students with disabilities. I shared four alternative amendments with the DDC, SCPD, and GACEC which would generally authorize accommodations in CPR course participation for students with disabilities and/or an outright exemption. The alternative amendments were forwarded to the Legislature on May 4. The DDC received a May 4 response indicating that the bill will include a conforming amendment. The email response was shared with the SCPD and GACEC.

I recommend soliciting a copy of the amendment and, assuming it is acceptable, endorsing the bill with amendment. As of May 8, the amendment does not appear on the legislative website.

14. S.B. No. 207 (Special Education “Childfind” & Hearing Panel Composition)

This bill was introduced on April 25, 2012. It passed the Senate with S.A. No. 1 on May 3.

The bill amends two statutes applicable to special education students.

First, it amends the existing “Childfind” statute. The current law already requires each district to identify, locate, and evaluate children with disabilities residing within the confines of the district. The bill adds provisions clarifying that the “Childfind” duty extends to children who are homeless, wards of the State, or are enrolled in private schools. The amendment excludes vocational school districts. The attached corresponding IDEA regulation, 34 C.F.R. 300.111, mentions the three categories of students included in S.B. NO. 207 (homeless; wards of state; attending private schools). However, the federal regulation also includes a requirement that Childfind address “highly mobile children, including migrant children.” See 34 C.F.R. 300.111(c)(2). Both S.B. No. 207 and the attached DOE Childfind regulation [14 DE Admin Code 923, §11] omit any reference to the latter category of children. It would be preferable to include the category in the bill to conform more closely to the corresponding federal regulation. Since the bill has already passed the Senate, a House amendment could be added or, at minimum, the Department could commit to amending its Childfind regulation to explicitly address this category of children.

Second, the legislation amends the existing special education hearing panel statute to delete a requirement that the attorney panelist be admitted to practice in Delaware. Instead, the qualifications are changed to an “attorney admitted to practice and in good standing with the bar of a state.” Based on prior discussions with DOE staff, I understand that the change is intended to allow the Department to include a law school professor who is an expert in special education law as an attorney panelist. Given the low incidence of hearings, it is somewhat difficult to develop an experienced cadre of attorney hearing officers. The proposed change provides some flexibility to allow an out-of-state attorney to serve on panels. However, in deference to the Delaware Bar, a narrower exception could have been considered instead of literally allowing general attorneys from Iowa, Nebraska, and Alaska to serve as Delaware hearing panelists. Line 15 could have adopted the following standard: “(1) One attorney either admitted to practice in the State or employed as a professor or instructor in an accredited law school with demonstrated expertise in special education law.”

I recommend sharing the above observations with policymakers with a courtesy copy to the Delaware State Bar Association.

15. SS No. 1 for S.B. No. 183 (DOC Educational Services)

The original S.B. No. 183 was introduced on March 22, 2012. The substitute bill was introduced on April 25, 2012. As of May 7, it remained in the Senate Finance Committee.

I have the following observations.

First, according to the synopsis, the legislation is intended to remove a section from the epilogue to the Budget Bill and incorporate it into Title 14 of the Code. For perspective, I am attaching Section 308 from the Governor's proposed budget bill (S.B. No. 175). The legislation essentially incorporates Section 308 into a new Section 2404 of Title 14 (lines 22-34).

Second, the bill also addresses prison education program staffing, staff qualifications, job duties, training, and GACEC review. However, there are several technical problems with these sections.

A. Lines 7-12 make no sense. The term "44.7" was apparently omitted at line 8. Compare the original bill at line 8. There are ostensibly other omissions and basic grammatical irregularities. For example, the second "sentence" reads as follows: "Prison Educational Program, 2.0 of these authorized secretaries will be located within a correctional facilities served."

B. Lines 14-17 are difficult to understand. The term "qualification" at line 14 should be "qualifications" to mirror the reference in line 15. Lines 16-17 recite as follows: "Teachers/supervisors are required to have or obtain School Leadership I as set forth in 14 Del.C. Ch. 12." I could not locate any reference to "School Leadership I" in Title 14 Del.C. Ch. 12. There is a reference to a "School Leader I" in the administrative code, 14 DE Admin Code 1592. However, it is limited to administrators while the bill also links teachers to the qualification.

C. At lines 47- 50, for grammatical reasons, consider the following substitute:

The Governor's Advisory Council for Exceptional Citizens will meet annually with Department of Education and Department of Correction representatives to review and assess the operation of the Prison Educational Program. To facilitate its review, the Council will conduct a site visit at least every other year which will include interviews with inmates, instructional staff, and security staff. The Council will include findings related to site visits and program review and assessment in its annual report.

I recommend sharing the above observations and recommendations with at least the prime sponsor of the legislation subject to consideration of also sharing them with the Senate Finance Committee.

16. H.B. No. 303 (School Based Health Centers: Insurer Reimbursement)

This bill was introduced on April 24, 2012. It was released from the House Economic Development/Banking/Insurance/Commerce Committee on May 2. The Committee Report is attached. Two amendments have been placed with the bill.

I have the following observations.

First, consistent with the synopsis, School Based Health Centers (SBHCs) exist in twenty-eight (28) Delaware high schools. The Centers offer a wide array of diagnostic and treatment services to students (lines 23-30 and 53-60). The bill is designed to implement a general Medicaid requirement that private insurance be billed for a covered service prior to billing to Medicaid (lines 9-10). The bill disallows an SBHC from charging a student a co-pay or out-of-pocket fee (lines 41-42 and 72-73). State-regulated health insurers would be required to reimburse SBHCs for the cost of services “as if those services were provided by a network provider” (lines 33-35 and 63-65). The amendments ostensibly address the sensitive issue of parental consent to reproductive services.

Second, there is a significant oversight in the legislation. Public schools may incorporate SBHC services into an IEP or Section 504 Plan (e.g. counseling; medical evaluation; school health services). Federal law bars billing a parent’s health insurance for services required for a free, appropriate public education (“FAPE”) without parental consent. A parent cannot be forced to allow access to his/her insurance if such access could potentially result in a “financial loss”. The attached HHS Policy Clarification [18 IDELR 558 (November, 1991)] summarizes the law:

Medicaid providers, including schools and their health care practitioners, must bill private plans first if a Medicaid recipient has private coverage for the relevant service. ...

Whether a school would actually choose to bill private insurers for services covered by more than one source of insurance would depend on the school’s policies regarding health insurance billing and the potential for an associated cost to the family. Under Federal policy on use of parents’ insurance proceeds, the requirements that a free, appropriate public education be provided “without charge” or “without cost” mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of children with disabilities would suffer a financial loss not incurred by similarly situated parents of other children. Financial losses include, but are not limited to, the following:

- A decrease in available lifetime coverage or any other benefit under an insurance policy;
- An increase in premium under an insurance policy; or
- An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.

At 561. See also attached OSERS Policy Letter to D.Rose, 18 IDELR 531 (September 19, 1991) [public agencies may not require parents to consent to filing of claim with private insurance or Medicaid]; and attached OSERS Policy Letter to G. Spinner, 18 IDELR 310 (November 13, 1991) [parents must give explicit consent to the filing of a claim by a public agency against their insurance policies to pay for required special education and related services where doing so poses a realistic threat of financial loss and be fully informed that refusal will not result in denial of services]. This policy applies to students covered by both the IDEA and Section 504 of the Rehabilitation Act. OSERS Policy Letter to G. Spinner, 18 IDELR 310, 311 (November 13, 1991). These policy interpretations are essentially reiterated in the relevant IDEA regulation, 34 C.F.R. 300.154.

Parenthetically, apart from students already identified under the IDEA or Section 504, the policy would also apply to students undergoing “Childfind” assessment of eligibility. “Childfind must be free. As the bill recites, SBHCs offer both mental health and physical health diagnostic assessments (lines 25-27).

Given the above considerations, the sponsors should consider adding the following subsection to the bill:

Insurer reimbursement to an SPHC for provision of services in fulfillment of an obligation under either the Individuals with Disabilities Education Act or Rehabilitation Act of 1973, codified at 20 U.S.C. 1400 and 29 U.S.C. 794 respectively, shall conform to any limitations established by such federal laws, including any requirement of parental consent and assurance of no adverse financial effect under a health insurance policy. The Division of Public Health, in consultation with the Department of Education, may issue regulations implementing this subsection.

I provided an advance copy of this commentary to the Councils on May 7 resulting in the forwarding of the attached May 7 SCPD memo to policymakers. On May 8, I reviewed the amendment with Rep. Q. Johnson who was predisposed to prefile the amendment with the bill. The legislation is on the House agenda for May 8 and hopefully will pass with the amendment.

#### 17. H.B. No. 311 (Mental Health Commitment)

This bill was introduced on May 1, 2012. A short, technical amendment was placed with the bill on May 2. The legislation is scheduled to be heard in the House Health & Human Development Committee on May 9.

Background on the bill is provided in the attached April 30, 2012 DHSS summary. The legislation is intended to “phase out” a system in which any physician can certify that an individual is a “dangerous mentally ill person” authorizing commitment to a mental hospital.

See lines 24, 28-31, and 37-39. It establishes a system of “credentialed mental health screeners” (lines 82-87) to conduct “up-front” assessments of individuals and authorize an initial 24-hour (adults) or 72-hour (children) commitment. It is intended to reduce the use of peace officers to provide commitment-related transportation (lines 88-93 and 141-143). Unfortunately, the legislation suffers from technical errors and would have benefitted from the opportunity for earlier input from stakeholders.

I have the following observations.

1. The bill “grandfathers” parts of the commitment process through July 1, 2013 (line 24 and 40). However, the bill immediately eliminates the definition of “dangerous mentally ill person” (lines 10-11) which is necessary to implement the “grandfathered” commitment process containing multiple references to “dangerous mentally ill person” (lines 28, 33, and 49). The definition needs to remain extant until July 1, 2013.

2. The legislation categorically excludes “dementia due to various etiologies” from the definition of a “mental condition” for which psychiatric hospital care can be sought (line 64). This would include individuals with traumatic brain injuries (often diagnosed under DSM IV 294.1 with “dementia due to head trauma”). TBI is the “signature” injury in the Iraq and Afghanistan conflicts and the categorical exclusion of TBI qualifying as a “mental condition” will adversely affect many veterans. Even individuals with TBI seeking voluntary admission to a psychiatric hospital would be effectively “barred at the door” (lines 197-199).

3. The legislation also contains an eligibility exclusion for an individual with a “developmental disability unless it results in the severity of impairment described herein” (lines 65-66). There is no definition of developmental disability in the bill. The common federal definition, codified at 42 U.S.C. 15002 (8), is as follows:

(8) Developmental Disability. -

(A) In general. - The term “developmental disability” means a severe, chronic disability of an individual that -

(I) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(ii) is manifested before the individual attains age 22;

(iii) is likely to continue indefinitely;

(iv) results in substantial functional limitations in 3 or more of the following areas of major life activity:

- (I) Self-care.
- (II) Receptive and expressive language.
- (III) Learning.
- (IV) Mobility.
- (V) Self-direction.
- (VI) Capacity for independent living.
- (VII) Economic self-sufficiency; and

(v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

(B) Infants and Young Children. - An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting 3 or more of the criteria described in clauses ( I) through (v) of subparagraph (A) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

The legislation covers both children and adults. A youngster with a diagnosis of major depression, bipolar disorder, or obsessive-compulsive disorder will often meet the federal definition of “developmental disability”. These conditions are also considered “biologically based mental illnesses” under the Delaware Code [Title 18 Del.C. §3578(3). Therefore, the exclusion at line 65 is manifestly “overbroad”.

4. Lines 69-72 contain three (3) masculine pronouns (his/his/he). Title 1 Del.C. §304(b) recites that “(w)ords importing the masculine gender include the feminine as well...”. Elsewhere, the bill refers to “his or her” (line 214). By analogy, the Delaware Manual for Drafting Regulations contains the following guidance:

3.3.2.1. Avoid using pronouns that indicate gender. Use the noun which the pronoun would replace. However, if the pronoun gender must be indicated, use “his” instead of “his/her” and “he” instead of “he/she” or “(s)he.” The use of the masculine gender is addressed in 1 Del.C. §304 of the Delaware Code.

It would therefore be preferable to use the noun that the pronoun would replace in these sections.

5. There is some tension between the requirement at line 83 that a “psychiatrist” possess a Delaware license and the contrary criteria in Title 16 Del.C. §5001(8). It would be preferable to use a consistent approach to who can qualify as a psychiatrist under the mental health commitment code.

6. Authorizing an “unlicensed” person to screen and authorize an involuntary commitment (line 84) is a very “weak” standard. The clinical decision to restrain liberty based on the criteria in the bill should arguably not be made by an unlicensed mental health worker. Anomalously, only a “licensed” practitioner can authorize a voluntary admission (line 197) while an “unlicensed” practitioner can authorize an involuntary admission.

7. The current Code (lines 30) grants medical personnel the “sole discretion” to authorize use of designated transport personnel. The bill reverses this approach in favor of law enforcement unilaterally determining the method of transportation (lines 91-93). This could be dangerous if a individual is presenting medical symptoms which may be correlated with a need for medical monitoring (e.g. by ambulance personnel) during transport.

8. In a related context, there is some “tension” between lines 91-93 (granting peace officer the authority to determine transportation) and lines 141-143 (granting Department the authority to determine transportation). This inconsistency may result in confusion. The synopsis implies that the health care provider determines the method of transport:

In place of the current system where a person is transported in handcuffs by police to a hospital emergency department, the bill allows a psychiatrist or credentialed mental health screener to evaluate a person anywhere and then transport that person to the most appropriate location for evaluation or treatment in the most appropriate and least restrictive manner.

9. Current law establishes an initial commitment period of 24 hours for adults and 72 hours for children (lines 42-43). The difference was based on the DSCY&F’s historical concern that psychiatrists might not be as readily available for assessment of children. This rationale may no longer be “apt” in 2012. It would be preferable to have a uniform 24-hour standard. The bill is very confusing in this context. The synopsis only refers to a 24-hour standard. Lines 102-109 and 137-169 solely refer to a 24-hour evaluation period and a “24-hour detention form”. Lines 77-81 refer to a 24-hour evaluation period for “an adult” without mentioning children. Lines 170-171 then anomalously recite that “(t)he 24-hour detention period referred to herein shall be seventy-two hours for minors”. This is an awkward and confusing approach which is counterintuitive.

10. In line 111, consider substituting “who” for “that”.

11. Line 148 refers to a “psychiatric advance directive as set forth in this chapter”. Although some states have discrete “psychiatric advance directives”, Delaware has only “advance health care directives”. See Title 16 Del.C. §2501. The reference should be amended



to conform to Delaware law.

12. Line 177 directs the State Treasurer to pay peace officers “at an agreed upon rate”. This is an odd reference. It suggests that peace officers from a variety of jurisdictions will negotiate different rates with the State Treasurer instead of the current statutory approach of having a uniform rate (lines 53-55). The latter approach is easier to budget and administer.

13. The liability exemption in lines 178-185 is extremely problematic. For example, it exempts anyone involved in the commitment process from civil liability or criminal prosecution in the absence of intentional/willful conduct. In the criminal context, this means that prosecution would be categorically barred irrespective of injury for a host of crimes based on “criminal negligence” and arguably any state of mind less than “intentional” (e.g. knowing; reckless). See Title 11 Del.C. §231. For example, if a person with a mental condition were victimized by criminally negligent conduct qualifying as Reckless Endangering in the Second Degree of a juvenile (Title 11 Del.C. §603) or Assault in the Third Degree (Title 11 Del.C. §611), prosecution would be barred. Indeed, the person with a mental condition could be killed through the negligence/malpractice of the hospital or others involved in the commitment process and criminal prosecution based on Criminally Negligent Homicide or Murder by Abuse or Neglect in the Second Degree would be categorically barred (Title 11 Del.C. §§631 and 633). The Legislature recently authorized special protections for persons with disabilities victimized by criminal conduct through creation of a “Crime Against a Vulnerable Adult statute (Title 11 Del.C. §1105). The exemption from criminal prosecution in this bill undermines that legislation.

Likewise, the civil liability exemptions are extremely overbroad. Even if civil litigation were initiated by the person with a disability, the bill literally bars the use of civil discovery. Then, instead of a victim having a burden to prove a claim by the preponderance of the evidence, the bill requires the victim to prove a claim by a stricter “clear and convincing evidence” standard (lines 183-184). If the Attorney General’s Office wished to issue a civil subpoena [Title 29 Del.C. §2504(4)] to investigate allegations involving a commitment, the bar on “civil discovery...for any harm allegedly resulting from the performance of (any person or entity’s) functions” could bar the subpoena.

The “bottom line” is that the exemption treats the person with mental illness as a “second class” citizen by eviscerating the right to pursue legitimate medical malpractice or similar claims. Individuals with mental illness can be victimized in the commitment process and the bill effectively bars redress.

14. Lines 207-208 authorize a legal guardian to consent to admission of a child to a psychiatric treatment facility. Likewise, line 218 allows a guardian to bar discharge of a child after initial commitment. There is some “tension” between these authorizations and the guardianship statute which recites as follows:

The guardian may not waive any right of the disabled person respecting involuntary commitment to any facility for the treatment of mental illness or deficiency.

Title 12 Del.C. §3922(b)(1). Section 3922 applies to guardians of children appointed by the

Court of Chancery [Title 12 Del.C. §3901].

15. The bill (lines 238-240) authorizes the DSAMH director to “trump” the entire Delaware Code and admit or discharge persons at DPC:

(h) Notwithstanding any other section of the Delaware Code, the Director of the Department’s Division of Substance Abuse and Mental Health shall have the independent authority to admit and discharge persons at the Delaware Psychiatric Center.

This is an extremely “dangerous” exception which would manifestly violate Constitutional due process. A single individual could authorize an indefinite restraint of liberty by fiat. Even on a practical basis, the DSAMH director does not have to be a psychiatrist. A social worker can serve as the DSAMH director. Title 29 Del.C. §7903(2)b.

16. Section 5127 (lines 242-256) is outdated and includes multiple references to processes which no longer exist. There is no “inquisition” to ascertain “insanity” (line 256). The reference to “trustee” in line 251 ostensibly relates to the repealed law which authorized appointment of a “trustee” rather than a “guardian” for persons with mental illness. For DHSS, it would be preferable to simply incorporate the more “up-to-date” Title 29 Del.C. Ch. 79. For DSCY&F, a similar cross reference could be made to Title 29 Del.C. §9019. In any event, I also recommend that a child not be made liable forever for the child’s cost of care as literally mandated by lines 243-246. For example, a child committed at age 10 to a psychiatric hospital and amassing a \$30,000 bill would be faced with a huge debt and collection efforts as an adult. This may not be in the public interest and is not authorized by the current DSCY&F liability statute, Title 29 Del.C. §9019.

17. Lines 287-288 recite as follows:

If the individual was, prior to admission, a person receiving services from the Department, such individual shall be discharged back to the relevant division of the Department for care and services with at least five days notice.

While well intentioned, there are two (2) concerns raised by this provision. First, it is unduly rigid to categorically require “discharge back to the relevant division” when a discharge plan might otherwise include a different disposition or referral to a different division. Second, it is pejorative to state that a person is being “discharged to a division”. The Bill of Rights contains a more flexible approach which could either be cross referenced or embellished. See Title 16 Del.C. §5161(b)(4).

18. Subsections (b) - (d) of Section 5131 (lines 290-300) merit repeal. The subsections describe an outdated process used in the 1970s and 1980s in which persons would be “released” but not “discharged”. It was the equivalent of being on indefinite probation with, at best, an annual “paper” review by a DPC administrator (line 295). DPC could then “prompt” the person’s return to DPC with no due process and effectively circumvent the commitment process and its procedural safeguards. CLASI would occasionally challenge such “returns” through

writs of habeas corpus authorized by Title 16 Del.C. §5013. See, e.g., attached Superior Court order by Judge Christie directing the release of person “returned” to DPC based on convalescent leave statute after 5 years in community.

Since this bill is scheduled to be heard in committee on May 9, I recommend promptly sharing the above observations with the Legislature, the ACLU, the Delaware Trial Lawyer’s Association, MHA, and NAMI-DE.

18. Federal ADA “Pool” Legislation (H.R. 4256; H.R. 4200; S. 2186; S. 2191)

A DLP senior attorney, prepared the following critique of the above federal legislation.

## **MEMO**

To: SCPD Policy and Law Committee  
From: Laura J. Waterland  
Subject: 112<sup>th</sup> Congress H.R. 4256; H.R. 4200; S. 2186; S. 2191  
Date: June 20, 2012

I am responding to a solicitation from the SCPD for technical assistance regarding pending legislation in Congress that limits the enforcement of United States Department of Justice regulations regarding the accessibility of swimming pools in places of public accommodation. As you know, in 2010 the USDOJ published comprehensive revisions to the ADAAG. One of the more controversial revisions relates to the requirements for newly constructed and existing pools. There are rules for larger and smaller pools, including spas and hot tubs, as well as wave pools and “lazy rivers.”

These requirements, which include installation of permanent lifts, were to go into effect March 15, 2012. The permanent lift requirement was not issued until January 2012. The lobbyists for the hotel and resort industry, as well as owners of theme parks, have been highly vocal and effective in their opposition to the these requirements, especially the requirement of installation of permanent lifts at each pool. Other groups that are opposed include alliances of homeowners and condo associations. The Attorney General, in response to the criticism, postponed the effective date for compliance on March 15, 2012 for 60 days and extended the time period for comment until April 4, 2012. The related notice of Proposed Notice of Rulemaking also contemplates extending the compliance period for an additional 6 months. (Attachments 1 and 2- USDOJ memoranda and PNRM ).

Congressman Mulvaney introduced legislation titled “Pool Safety and Accessibility for Everyone (Pool SAFE) Act” ( H.R. 4256). There are 26 original sponsors. The companion bill in

the Senate is S. 2390, introduced by Senator Lindsey Graham. This bill extends the compliance date for the regulations for one year and modifies the lift requirement to allow for temporary lifts that can be shared between pools at the same facility. The statute also prevents enforcement action for one year. Both bills are now assigned to committee. There was a hearing scheduled on this bill on April 24, 2012. (Attachment 3- Bill text).

There is additional related legislation currently pending. H.R. 4200, S. 2186 and 2191 prevent the USDOJ from administering or enforcing accessibility regulations related to pools, without qualification as to time or content. This legislation would certainly be a disturbing precedent and would encourage any special interest group representing entities covered by the ADA to seek out legislation that excludes them from enforcement. It would badly undercut the scope and effectiveness of the ADA. (Attachment 4- Bill text).

Disability advocates are opposed to the legislation, not only because of the content, but also because of the way in which it could undercut the DOJ's ability to enforce the ADA and the ADA itself. It may be that the legislation is simply a way to put pressure on the DOJ to reinterpret (again) the standards for pools. The additional time for comment should allow the DOJ to publish standards that address the concerns of pool owners and operators.

#### Attachments

8g:leg/512bils  
F:pub/bjh/legis/2012/512bils