MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory Initiatives

Date: July 3, 2012

I am providing my analysis of ten (10) regulatory initiatives in anticipation of the July 12 meeting. Given time constraints, the commentary should be considered preliminary and non-exhaustive.

1. DMMA Final State Plan Amendments Regulation [16 DE Reg. 72 (July 1, 2012)]

The SCPD and GACEC commented on the proposed version of this regulation in May, 2012. The Councils endorsed the proposal with no suggested changes. The Division has now acknowledged the endorsements and adopted a final regulation which conforms to the proposed version.

I recommend no further action.

2. DSS Child Care Subsidy Program Definitions Reg. [16 DE Reg. 78 (July 1, 2012)]

The SCPD and GACEC commented on the proposed version of this regulation in May, 2012. A copy of the May 24, 2012 GACEC letter is attached for facilitated reference. The Division of Social Services has now adopted a final regulation incorporating some edits recommended by the Councils.

First, the Councils endorsed a new definition of "children from low income families". The Division acknowledged the endorsement.

Second, the Councils recommended an amendment to the definition of "child". DSS concurred and effected the amendment.

Third, the Councils recommended an amendment to the definition of "child care centers". The Division concurred and effected the amendment.

Fourth, the Councils recommended a minor grammatical change to the definition of "child care certificate". The Division concurred and effected the amendment.

Fifth, the Councils recommended some minor grammatical changes to the definition of "educational program". The Division concurred and effected the amendments.

Sixth, the Councils noted that the Division had deleted the word "dysfunctional" from the definition of "physical or mental incapacity". The Councils observed that the deletion conformed to Title 29 Del.C. §608. DSS responded that the deletion was an error and reinstated the word "dysfunctional".

Since the regulation is final, and DSS addressed each of the Councils' comments, I recommend no further action.

3. DOE Final Data Governance Regulation [16 DE Reg. 67 (July 1, 2012)]

The SCPD and GACEC commented on the proposed version of this regulation in May, 2012. A copy of the May 16, 2012 GACEC letter is attached for facilitated reference. The Department of Education has now adopted a final regulation with two (2) minor edits prompted by the commentary.

First, the Councils observed that the definition of "education record" could be construed as omitting private elementary, secondary, post-secondary, and trade schools which do not receive federal funds but may be subject to DOE regulation. The Department responded that it interpreted the definition as applicable "to any education agency or institution". At 68. However, it inserted two (2) comments for clarity.

Second, the Councils shared a concern that the regulation was too narrow in its coverage of "research". The Department disagreed and effected no amendment.

Since the regulation is final, and the DOE addressed each of the Councils' comments, I recommend no further action.

4. DSS Prop. Child Care Subsidy Program Tech. Eligibility Reg. [16 DE Reg. 47 (July 1, 2012)]

The Division of Social Services proposed to amend a child care subsidy program eligibility regulation. There is one substantive change, i.e., clarification that parents/caretakers must be Delaware residents. See Summary of Proposed Changes (p. 48) and §1.A. Otherwise, the Summary of Proposed Changes section reflects the following rationale for amendments:

> The name of the section is changed to more accurately indicate the content of the policy. This policy section is reformatted and clarifying language is also provided to make the rules easier to understand and follow. Specifically, this regulatory action adds the eligibility requirement that parents/caretakers must be Delaware residents. The applicable federal citation is also added to the policy section.

At 48.

I have two (2) recommendations.

First, §3.C refers to "(o)btaining status as a a sy lee." The error appears in both the printed and on-line version of the regulation. Based on the current Administrative Code version of the regulation, the reference should be "(o)btaining status as an asylee." The Webster's Dictionary definition of an "asylee" is attached.

Second, as noted above, the Summary of Proposed Changes indicates that the regulation is being reformatted for clarity. Unfortunately, while the current regulation contains punctuation, the proposed version omits corresponding punctuation. Consider the following:

- Subsection 1.A should have a concluding period.
- Subsections 1.B. 1-6 omit semicolons and Subsection 1.B. 7 should have a concluding period.
- Subsection 2.A omits a semicolon; Subsection 2.B should conclude with "; or"; and Subsection 2.C should have a concluding period.
- Subsections 3.A. and B lack concluding semicolons.
- Subsections 3.C. A omits a concluding semicolon;
- Subsection 3.C.B. should conclude with "; or"; and
- Subsection 3.C.C. lacks a concluding period.

Third, the Division should consider converting Subsections 1.C., Pars. A-C, to Pars. 1-3. Compare Subsection 1.B., Pars. 1-7.

I recommend endorsement subject to consideration of the above recommended edits.

5. DSS Prop. Expedited Fair Hearing Regulation [16 DE Reg. 6 and 30 (July 1, 2012)]

The Division of Medicaid & Medical Assistance has published both an emergency and proposed regulation amending its fair hearing process to specifically address expedited fair hearings available to Medicaid and Delaware Healthy Children Program (DHCP) participants. DHSS noted the omission during the CMS review of the DSHP Plus review process. At p. 31.

I identified two (2) concerns with the proposed revisions.

First, §5304.3, Par. 1 (p. 36) indicates that the "MCO must issue an expedited resolution within 3 working days after receiving the appeal." Obviously, a claimant attempting to persuade an MCO to issue a favorable decision within the "3 working days" timeframe would ordinarily benefit from reviewing the MCO's case records to facilitate any submission of justification or expert medical evidence. Unfortunately, there is no DSS regulation addressing expedited access to MCO case records. It would be preferable to add a provision requiring prompt access to such records in the context of a request for expedited resolution.

Second, if a claimant requests a fair hearing to contest an MCO's adverse decision processed under the expedited resolution regulation [§5403.3, Par. 1], the DSS hearing officer is expected to issue a decision within 3 working days. See §5500, Par. 1; and 42 C.F.R. §431.244(f)(2). However, §5403, Par. 2, allows the MCO or agency to wait "3 working days" to provide access to case records. Thus, a claimant would be "hamstrung" in preparing for the expedited hearing since he/she would lack timely access to MCO or State agency case records. CMS regulations mandate that beneficiaries will have access to records before the date of hearing to allow meaningful participation in the appeal process. See, e.g., 42 C.F.R. §431.242(a). Therefore, I recommend that §5403, Par. 2, be revised as follows:

> For expedited resolution requests, case records must be promptly made available within ~~3 working days~~ 1 working day of the receipt of the appeal.

I recommend sharing the above observations with DMMA.

6. DMMA Prop. Medicaid Telemedicine Regulation [16 DE Reg. 44 (July 1, 2012)]

The Division of Medicaid and Medical Assistance proposes to adopt a regulation allowing use of a telemedicine delivery system for providers enrolled under the Delaware Medicaid program.

I have the following observations.

First, authorizing telemedicine offers many advantages to individuals with disabilities, including less transportation time and expense in reaching providers and improved access to subspecialties not widely available in a local area. The concept therefore merits endorsement.

Second, the standards omit any requirement that the use of telemedicine be considered only when it is consistent with effective communication. The Americans with Disabilities Act generally contemplates accommodations to ensure effective communication between medical providers and patients. See attachments. Therefore, it would be preferable to "highlight" this consideration in the regulation since it could otherwise be inadvertently overlooked. The following sentence could be added:

The provision of services through telemedicine must include accommodations, including interpreter and audio-visual modifications, if necessary to ensure effective communication.

Third, in Section 27, "Provider Qualifications", second paragraph, first bullet, the verb/predicate has been omitted and the word "within" is misspelled. Consider the following amendment: "Act within their scope of practice".

Fourth, in the "Covered Services" section, the reference to "illness or injury" is "underinclusive" since it would exclude diagnoses and treatment of "conditions" such as cerebral palsy or epilepsy. Medicaid covers more than illnesses and injuries. Compare attached DHSS definition of "medical necessity".

I recommend sharing the above observations and recommendations with DMMA.

7. DMMA Prop. LTC Ombudsman Program Regulation [16 DE Reg. 42 (July 1, 2012)]

The Division of Medicaid & Medical Assistance proposes to adopt an amendment to the Medicaid State Plan.

As the "Summary of Proposal" section (p. 43) indicates, transfer of three (3) State long-term care facilities (DHCI, EPBH, and GBHC) to DSAAPD in the FY11 budget bill created a conflict of interest. The conflict resulted from the DSAAPD Division Director supervising both the State LTC facilities and the Ombudsman since the Ombudsman is expected to be an independent monitor of LTC facilities. To resolve the conflict, legislation (S.B. No. 102) was enacted to place the Ombudsman under the Office of the Secretary. The proposed regulation merely revises the Medicaid State Plan to reflect this change. It merits endorsement.

However, consistent with the attached June 21, 2011 SCPD comments on S.B. No. 102, the SCPD secured a DHSS commitment to address the following: 1) conflicts between DHSS Administration and the Ombudsman; and 2) the need to ensure the availability of independent legal counsel to the Ombudsman. I recommend that the SCPD follow up to assess whether the Department ever implemented its commitment.

8. DMMA Proposed Nursing Facility Quality Assessment Reg. [16 DE Reg. 38 (July 1, 2012)]

The Division of Medicaid and Medical Assistance proposes to adopt a Medicaid State Plan amendment to implement S.B. No. 227 which was signed by the Governor on June 28, 2012.

As the Summary of Proposal section (p. 39) indicates, Medicaid reimbursement rates to nursing facilities "have been frozen since April 1, 2009 at the level they were as of December 31, 2008." DMMA proposes to impose a quality assessment "tax" on nursing home providers which would generate federal Medicaid matching funds. See S.B. No. 227, lines 35-38 and 118-119. Ninety percent (90%) of the collected quality assessment funds will be deposited in a Nursing Facility Quality Assessment Fund (lines 71-72) and ten percent (10%) will be diverted to the Delaware's General Fund (line 73). The "90%" in the Quality Assessment Fund would be used to increase nursing facility rates. DMMA anticipates increasing payments to nursing facilities by $29 million in State FY13. See regulatory "Fiscal Impact Statement" at p. 39. I infer that the federal match is being used to essentially offset the additional payments to nursing facilities. Some nursing facilities would be exempt from the assessment, including State-run facilities and facilities that exclusively serve children. See regulatory Section "(c)" on p. 41.

I have only one (1) technical observation. Literally, S.B. No. 227 requires all nursing facilities to be charged a quality assessment unless exempt under §6502(d). See lines 35-38 and 58-68. One would therefore expect the exemptions in the regulation (p. 41) to match the exemptions in §6502(d). They do not match. For example, the bill requires DHSS to exempt facilities with 46 or fewer beds and continuing care retirement communities (lines 62-65). The regulation [§(c)] on p. 41], does not exempt such facilities. Moreover, the regulation lists several facilities as exempt which are not exempt under the legislation.

I recommend sharing the above commentary with the Division.

9. DLTCRP Prop. LTC Discharge & Impartial Hearing Reg. [16 DE Reg. 24 (July 1, 2012)]

The Division of Long Term Care Residents Protection issued an earlier version of this regulation in April, 2012. See 14 DE Reg. 1405 (April 1, 2012). The SCPD and GACEC submitted an extensive critique of that initiative which identified many concerns. A copy of the SCPD's April 24, 2012 commentary is attached for facilitated reference. The Division has now issued a completely revised proposed regulation. Unfortunately, the Division's proposed standards remain problematic. I have the following observations and recommendations.

1. In its April 24 commentary, Par. 1, the SCPD noted that 57% of Delaware nursing home patients are funded by Medicaid. These patients have a federal right to contest a discharge or transfer with certain protections that were not included in the April version of the regulation. DHSS regulations specifically apply the hearing procedures codified at 16 DE Admin Code Part 5000 to appeals by Medicaid beneficiaries of proposed nursing home discharges and transfers. The SCPD therefore commented that "the better approach would be to adopt or incorporate the Part 5000 regulations as the standards for discharges and transfers from all licensed long-term care facilities." Instead of adopting this approach, the July version of the regulation has 2 sets of standards applicable to the following facilities: 1) Section 3.0 applies to nursing facilities which participate in the Medicaid or Medicare programs; and 2) Section 4.0 applies to State-licensed long-term care facilities. There are several problems with this approach:

A. A discharge from an ICF/MR (e.g. Stockley; Mary Campbell) is not covered by Section 3.0 (since exempt from 42 C.F.R. §483.5) and the procedures in Section 4.0 are not co-terminous with those in 42 C.F.R. §§431.210 - 431.246.

B. If the State proposed to discharge a Medicaid beneficiary from a State-run nursing facility (GBHC; Bissell; DHCI), the beneficiary has a right to a Medicaid hearing under 16 DE Admin Code Part 5000 which conforms to the procedures mandated by Ortiz v. Eichler. Neither Section 3.0 nor Section 4.0 of the DLTCRP regulation complies with Ortiz and the regulation will confuse Medicaid beneficiaries of State-run nursing facilities into believing that only the DLTCRP process applies.

C. Section 3.0 applies to nursing homes participating in the Medicare program pursuant to 42 C.F.R. §483.5. Federal law authorizes Medicare beneficiary appeals of proposed nursing home discharges through a QIO. See attached Quality Insights Delaware publication, "How to Appeal if your Services Are Ending". Time periods to contest the discharge are very short. Medicare beneficiaries will likely be confused concerning the overlapping Medicare and DLTCRP appeal systems. At a minimum, the DLTCRP regulation should include an explanatory comment or note highlighting the availability of both appeal systems.

D. For nursing facilities which are covered by both Section 3.0 (Medicaid/Medicare enrolled) and Section 4.0 (State licensed under 16 Del.C. Ch. 11), it is unclear if only Section 3.0 applies or both Sections 3.0 and 4.0 apply.

2. In Section 2.0, the definition of "transfer and discharge" is problematic. The definition is as follows:

> "Transfer and discharge" includes movement of a resident to a bed outside of the licensed facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same licensed facility.

The April version of the regulation contained a similar definition which limited "transfer and discharge" to removal to another facility. The SCPD objected to the narrow definition which, while based on 42 C.F.R. §483.12(a)(1), categorically presumes that all persons whose residency is terminated go to another facility. To the contrary, involuntarily discharged residents, including those discharged for nonpayment, may go to a relative's home, a homeless shelter, or "the street". Under the proposed definition, the regulation (and its protections) would be inapplicable to terminations of residency if the resident is expected to go to a relative's home, a homeless shelter, or "the street".

3. Section 3.3.1 could be amended as follows to conform to Title 16 Del.C. §§1121(34) and 1122.

> Notify the resident and, if known, a family member or legal representative of the resident, including an agent authorized to act on the resident's behalf pursuant to Title 16 Del.C. §1121(34) and 1122, of the transfer or discharge and the reasons for the move in writing

and in a language and manner they understand.

However, the result is a lengthy, convoluted sentence. It would be preferable to simply add a definition of "legal representative" in Section 2.0 as follows:

> "Legal representative" includes a resident's guardian; agent acting through a power of attorney, advance health care directive, or similar document; or authorized representative pursuant to Title 16 Del.C. §§1121(34) and 1122.

4. Section 3.3.2 merits revision. It is loosely based on 42 C.F.R. §483.12(a)(6). First, references to "developmentally disabled individuals" and "mentally ill individuals" are not "people-first" and violate Title 29 Del.C. §608(b)(1)a. Second, unlike the federal regulation, it is ambiguous in defining when notice should be given to the P&A. The facility would, with no guidance, determine if such notice is "applicable" and may have to "guess" at the identity of the P&A. Third, there are other key agencies which should also receive notice, including the DSHP Plus MCO and any DHSS agency (APS; DDDS) involved in the placement. Consider the following substitute:

> 3.3.2. Provide a copy of the notice to the Division; the State LTC ombudsman; the resident's Delaware Medicaid managed care organization (MCO), if any; any DHSS agency involved in the resident's placement in the facility, including APS; and the protection and advocacy agency as defined in Title 16 Del.C. §1102 if the resident is an individual with a developmental disability or mental illness.

5. In §3.4.2.4, delete the comma after the word "needs".

6. Sections 3.5.6 and 3.5.7 are based on 42 C.F.R. §§483.12(a)(6). I recommend combining §§3.5.6 and 3.5.7 as follows:

> For nursing facility residents with a developmental disability or mental illness, the mailing address and telephone number of the Delaware protection and advocacy agency as defined in Title 16 Del.C. §1102.

Delaware's P&A for individuals with developmental disabilities and mental illness is the same agency.

7. As applied to Medicaid-funded residents, §3.5 is overtly deficient since it fails to comply with the permanent injunction imposed on DHSS through Ortiz and implemented through 16 DE Admin Code Part 5000, §5300. See also 42 C.F.R. §§431.210 (requiring regulatory citations). Cf. attached In the Matter of the Hearing of Marie J, DCIS No. 036864 (Del. DES 1987). Thus, if the discharge is based on nonpayment, the notice must include the calculations. The notice must include the citations to the regulation(s) supporting discharge. The notice must "contain any information needed for the claimant to determine from the notice alone the accuracy of the agency's intended action" and "provide a detailed individualized explanation of the reason(s) for the action being taken". These requirements should be added to §3.5.

8. Section 3.5.4 contemplates provision of notice to a resident that there is a right to appeal to the State without identifying how to invoke the right. To be meaningful, the notice should include the procedure for requesting a hearing. See §5.1.1. Compare 16 DE Admin Code, Part 5000, §5300, Par. 1.B.

9. Section §3.8 could result in violations of State law. The implication is that a facility can change a resident's room within the same building as of right. This is reinforced by §4.8. However, State law requires the facility to honor the room request of a resident unless impossible to accommodate. See Title 16 Del.C. §1121(28) and compare §4.8.3. Moreover, a facility must honor the requests of spouses to share a room if feasible and not medically contraindicated. Section 3.8 should be amended to clarify that a facility's discretion to transfer residents to another room in the same building is limited by Title 16 Del.C. §§1121(13) and 1121(28).

10. If §3.0 is a "stand alone" regulation which excludes application of §4.0, §3.9.3 would violate State statute [Title 16 Del.C. §1121(18)] since readmission is not limited to Medicaid beneficiaries. Every LTC resident who is returning from an acute care facility is entitled to be offered the next available bed.

11. Strict enforcement of Title 16 Del.C. §1121(18) should be the norm. However, if the Division is disinclined to strictly enforce resident readmission rights accorded by §3.9.3 and Title 16 Del.C. §1121(18), it should at least consider the addition of a §3.11 to read as follows:

> 3.11 If a facility issues a discharge notice rather than permitting a resident's readmission under this section, and the resident requests a hearing to challenge the discharge, the Department, without limiting its discretion to exercise other statutory or regulatory authority, may, during the pendency of proceedings, direct the resident's readmission or place limitations on the facility's admissions to preserve one bed. In exercising its discretion, the Department will consider the following:
>
> 3.11.1 Historical bed turnover rates in the facility;
>
> 3.11.2 Availability of public or private funding for costs of care;
>
> 3.11.3 Adverse health and quality of life consequences of delaying readmission; and
>
> 3.11.4 Federal and State public policy preferences for provision of services in the least restrictive setting.

12. Consistent with the commentary under Par. 3 above, §4.3.1 could be amended as follows to conform to Title 16 Del.C. §§1121(34) and 1122:

> Notify the resident and, if known, a family member or legal representative of the resident, including an agent authorized to act on the resident's behalf pursuant to Title 16 Del.C. §1121(34) and 1122, of the transfer or discharge and the reasons for the move in writing

and in a language and manner they understand.

However, the result is a lengthy, convoluted sentence. It would be preferable to simply add a definition of "legal representative" in Section 2.0 as follows:

> "Legal representative" includes a resident's guardian; agent acting through a power of attorney, advance health care directive, or similar document; or authorized representative pursuant to Title 16 Del.C. §§1121(34) and 1122.

13. Consistent with the commentary under Par. 7 above, §4.5 merits revision. As applied to Medicaid-funded residents, §4.5 is overtly deficient since it fails to comply with the permanent injunction imposed on DHSS through Ortiz and implemented through 16 DE Admin Code Part 5000, §5300. See also 42 C.F.R. §§431.210 (requiring regulatory citations). Cf. attached In the Matter of the Hearing of Marie J, DCIS No. 036864 (Del. DES 1987). Thus, if the discharge is based on nonpayment, the notice must include the calculations. The notice must include the citations to the regulation(s) supporting discharge. The notice must "contain any information needed for the claimant to determine from the notice alone the accuracy of the agency's intended action" and "provide a detailed individualized explanation of the reason(s) for the action being taken". These requirements should be added to §4.5.

14. Section 4.5.4 contemplates provision of notice to a resident that there is a right to appeal to the State without identifying how to invoke the right. To be meaningful, the notice should include the procedure for requesting a hearing. See §5.1.1. Compare 16 DE Admin Code, Part 5000, §5300, Par. 1.B.

15. As noted under Par. 6 above, §§ 4.5.6 and 4.5.7 are based on 42 C.F.R. §§483.12(a)(6). I recommend combining §§4.5.6 and 4.5.7 as follows:

> For nursing facility residents with a developmental disability or mental illness, the mailing address and telephone number of the Delaware protection and advocacy agency as defined in Title 16 Del.C. §1102.

Delaware's P&A for individuals with developmental disabilities and mental illness is the same agency.

16. Consistent with the comments under Par. 9 above, §4.8 could result in violation of State law. The implication is that a facility can change a resident's room within the same building as of right subject only to §4.8.3. A facility must honor the requests of spouses to share a room if feasible and not medically contraindicated. Section 4.8 should be amended to clarify that a facility's discretion to transfer residents to another room in the same building is limited by both Title 16 Del.C. §§1121(13) and 1121(28).

17. Strict enforcement of Title 16 Del.C. §1121(18) should be the norm. However, consistent with Par. 11 above, if the Division is disinclined to strictly enforce resident readmission rights accorded by §4.9.2 and Title 16 Del.C. §1121(18), it should at least consider the addition of a §4.9.3 to read as follows:

4.9.3 If a facility issues a discharge notice rather than permitting a resident's readmission under this section, and the resident requests a hearing to challenge the discharge, the Department, without limiting its discretion to exercise other statutory or regulatory authority, may, during the pendency of proceedings, direct the resident's readmission or place limitations on the facility's admissions to preserve one bed. In exercising its discretion, the Department will consider the following:

4.9.3.1 Historical bed turnover rates in the facility;

4.9.3.2 Availability of public or private funding for costs of care;

4.9.3.3 Adverse health and quality of life consequences of delaying readmission; and

4.9.3.4 Federal and State public policy preferences for provision of services in the least restrictive setting.

18. In §4.9, there is no definition of "acute care facility", the term used in Title 16 Del.C. §1121(18). The following definition should be added to §2.0:

"Acute care facility" means a health care setting providing intensive services of a type or level not readily available in the current facility, including, without limitation, settings licensed or certified pursuant to chapters 10, 11, 22, 50, or 51 of Title 16.

19. There is some "tension" between §§5.1.1.2-5.1.1.3 versus §§3.5.4 and 4.5.4. The hearing request should be submitted to the State, not to the provider with a "cc" to the State. Moreover, it is unclear if §5.1.1.3 (contemplating a "cc" to the DLTCRP and Ombudsman) is "directory" or a sine qua non for perfection of the appeal. In the latter case, a pro se resident who did not send a copy to the Ombudsman could have his/her appeal dismissed. This would be an unfortunate result.

20. Section 5.1.1.2 categorically applies a minimum 30-day appeal timeline. A Medicaid beneficiary requesting a hearing to contest discharge from a State-run nursing facility, an ICF/MR, or other LTC facility would ostensibly have 90 days to request a hearing. Compare 42 C.F.R. §§431.206(c)(3) and 431.221(d); and 16 DE Admin Code Part 5000, §§5001, Par. 2 C; 5307, Par. C.2; and 5401, Par. C.3. This is not addressed anywhere within the DLTCRP regulation.

21. Section 5.4 omits the right to examine case records regardless of their lack of intended use in the proceedings. Compare 42 C.F.R. §431.242(a)(1); 42 U.S.C. §483.10(b)(2); Title 16 Del.C. §1121(19); and 16 DE Admin Code, Part 5000, §5403. A reference to this right should be added.

I recommend sharing the above observations and recommendations with the DLTCRP with a courtesy copy to Rep. Osienski. The SCPD should also separately submit a copy to the Department's policy analyst, Debbie Gottschalk, to remind the Department of prior discussions concerning Par. 18.

10. DOE Prop. Health Exams & Screening Regulation [16 DE Reg. 20 (July 1, 2012)]

In 2011, the Department of Education proposed a regulation to require a second health examination for students entering 9th grade. The SCPD and GACEC endorsed the proposed regulation subject to changing terminology from "physical examination" to "health examination". The DOE adopted a final regulation which incorporated that change. See 15 DE Reg. 432 (October 1, 2011) (proposed); 15 DE Reg. 838 (December 1, 2011) (final). The DOE is now delaying mandatory implementation of the regulation by one (1) school year, i.e. , the regulation would be effective with the 2013-2014 school year rather than the 2012-2013 school year. The regulation would "strongly recommend" the second health exam but not "require" it for the 2012-2013 school year. At p. 21.

The rationale is as follows: "The delay for required implementation is to provide additional time for parents and guardians to be advised and to prepare for the new requirement." At p. 20.

I recommend that the Councils comment that they would have preferred full implementation with the 2012-13 school year but understand DOE's rationale for allowing additional time to "roll out" the new requirement.

Attachments

8g:legreg/712bils
F:pub/bjh/legis/2012p&l/712bils