



DISABILITIES LAW PROGRAM

COMMUNITY LEGAL AID SOCIETY, INC.

100 W. 10th Street, Suite 801
Wilmington, Delaware 19801
(302) 575-0660 TTY (302) 575-0696 Fax (302) 575-0840
www.declasi.org

MEMORANDUM

To: SCPD Policy & Law Committee
From: Brian J. Hartman
Re: Legislative & Regulatory Initiatives
Date: May 7, 2013

I am providing my analysis of seven (7) legislative and ten (10) regulatory initiatives in anticipation of the May 9 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. DMMA Final Medicaid Primary Care Services Payment Reg. [16 DE Reg. 1176 (May 1, 2013)]

The SCPD and GACEC commented on the proposed version of this regulation in March. A copy of the March 27, 2013 SCPD memo is attached for facilitated reference.

The Councils endorsed the initiative since required to conform to federal law and CMS guidance. The Division of Medicaid & Medical Assistance has now acknowledged the endorsements and adopted a final regulation with no additional changes.

I recommend no further action.

2. DPH Final Newborn Screening Regulation [16 DE Reg. 1182 (May 1, 2013)]

The SCPD and GACEC commented on the proposed version of this regulation in February. A copy of the February 27, 2013 GACEC letter is attached for facilitated reference. The GACEC letter included two (2) comments not contained in the SCPD's memo. The Division of Public Health has now adopted a final regulation which incorporates edits prompted by each of the Councils' comments.

First, the Councils recommended a grammatical change in §1.0. The Division agreed and modified the provision.

Second, the Councils recommended deletion of the word "certain" in §1.0. The Division deleted the word.

Third, the Councils recommended use of the term “facility” rather than “institution”. The Division agreed and substituted “facility” for “institution” in several sections.

Fourth, the Councils recommended substitution of “results” for “result” in §2.0. The Division substituted “results”.

Fifth, the Councils suggested that the word “health” was inadvertently omitted in §4.0. The Division inserted the word “health”.

Sixth, the Councils questioned deletion of a “3- day” time period. The Division reinstated the “3-day” time period.

Seventh, the Councils noted the omission of language in §7.1. The Division revised the language.

Eighth, the GACEC noted redundant use of the term “hospital” in §§7.1 and 7.2. The extraneous reference was deleted.

Ninth, the GACEC identified a typographical error in §7.1.2. The Division removed the section.

Tenth, the Councils questioned whether the term “hereditary disorders” in §11.0 was too narrow. The Division removed the restrictive term.

Since the regulation is final, and the Division adopted edits based on each of the Councils’ comments, I recommend sending a “thank-you” communication.

3. DSS Final Case Administration Regulation [16 DE Reg. 1191 (May 1, 2013)]

The SCPD and GACEC commented on the proposed version of this regulation in March. The GACEC added a few comments not contained in the attached SCPD memo. However, the Division of Social Services only addressed the SCPD’s commentary, perhaps based on the impression that the SCPD and GACEC comments were co-terminus.

First, the SCPD noted that an authorization to release records to a court-appointed guardian ad litem was “overbroad”. The Division agreed and conformed the standard to statute.

Second, the SCPD observed that an authorization to release confidential information in connection with civil proceedings was likewise “overbroad” based on federal regulations. The Division agreed and edited the provision.

Third, the SCPD suggested that the Division consider authorizing electronic “sending” of records. The Division responded that it is in the process of converting records to electronic format but did not amend the regulation.

Fourth, the SCPD identified some inconsistent record retention standards in §1005. The Division amended references to achieve consistency.

Fifth, the SCPD recommended deletion of the term “not” in §1006.1. The Division deleted the term.

Sixth, the SCPD observed that §1008 only addressed access to records at “bricks and mortar” sites and omitted references to statutory access to records via a web portal. The Division added a reference to the web address to access policy information.

Since the regulation is final, I recommend no further SCPD action. The GACEC may wish to communicate with DSS concerning its overlooking of supplemental GACEC comments.

4. DDDS Final Autism Service Providers Regulation [16 DE Reg. 1170 (May 1, 2013)]

The SCPD and GACEC commented on the proposed version of this regulation in March. Comments were also submitted by CLASI, Autism Delaware, and the Delaware Association of Behavior Analysis. The March 27, 2013 SCPD commentary is attached for facilitated reference. The Division of Developmental Disabilities Services has now adopted a final regulation incorporating almost all revisions promoted by the Councils.

First, the Council objected to adoption of a narrower definition of “applied behavior analysis” than contained in the enabling legislation. The Division agreed and adopted the statutory definition.

Second, in §2.0, the Council suggested that a reference to “BCBA-D” should be included. In response, the Division modified the definition of “Autism Services Provider”.

Third, the Council recommended revision of the definition of “autism service provider” to refer to the regulation. The change was effected.

Fourth, the Council recommended insertion of the word “acting” in the definition of “therapeutic care”. The change was made.

Fifth, the Council recommended deletion of the term “to be” in §3.1. The term was deleted.

Sixth, the Council recommended substitution of “it certifies” for “they certify” in §3.1. DDDS adopted the substitution.

Seventh, the Council recommended an amendment to the reference to Behavior Analyst Certification Board standards. DDDS adopted a conforming amendment.

Eighth, the Council recommended substitution of “2.2” for “2.0” in §3.2. The change was made.

Ninth, the Council recommended a revision to reference to “should reflect”. The entire sentence containing the term was deleted.

Tenth, the Council recommended substituting “hours per week” for “hours a week”. The entire sentence containing the term was deleted.

Eleventh, the Council recommended revision of a reference to “supervision”. No change was made.

Twelfth, the Council recommended multiple revisions of standards related to supervision. The standards were revised to conform to suggestions of Autism Delaware and The Delaware Association for Behavior Analysis.

Thirteenth, the Council recommended clarification that a reference in §3.3 applies to “behavioral technicians”. DDDS added a clarifying reference to “behavioral technicians”.

Fourteenth, the Council recommended deletion of a period. The change was not made.

Since the regulation is final, and the Division adopted amendments in response to most Council comments, I recommend no further action.

5. DFS Prop Criminal History Record Check Regulation [16 DE Reg. 1152 (May 1, 2013)]

The DFS Office of Child Care Licensing is proposing to adopt revisions to its standards covering criminal background checks for individuals involved in residential child care. I have the following observations.

First, in §1.0, I recommend substituting “Basis” for “Base” in the title.

Second, in §3.0, definition of “Child Care Person”, DFS ostensibly forgot to delete some internal notes. The following reference appears twice in the regulation: “(Since definitions are not numbered we would have to use the definition title)”.

Third, in §3.0, delete “(see ‘Direct Access’ below)” and “See definitions ‘Foster Parents’ and ‘Volunteer’ below.”.

Fourth, there is an inconsistency between §3.0, definition of “direct access”, and §4.1.4.1. The former standard defines “direct access” as excluding contexts in which “another child care person” is present while the latter standard “muddies the waters” by characterizing “direct access” as opportunity for contact outside the “presence of other employees or adults”. The latter reference would include persons who have not undergone the screening for a “child care person”. The latter reference would also include contact by “phone” or other media. I recommend the following amendment to §4.1: “The opportunity to have direct access to ~~or contact with~~ a child ~~without the presence of other employees or adults.~~” The definition of “direct access” renders the “strike-out” language surplusage.

Fifth, in §3.0, the definition of “direct access” excludes individuals who are proximate to a child if another child care person is present. This should be reconsidered.

A. The statutory definition of “child care personnel” (Title 31 Del.C. §309), which includes a reference to “regular direct access”, is not limited to persons who would be “alone” with a child. If DFS defines “direct access” to only cover personnel who would be regularly “alone” with children, employers may justifiably exclude many child care workers from the background check process.

B. There are situations in which perpetrators act as a team to abuse/neglect children. Just because someone is not alone with a child does not mean that the child is not at risk.

Sixth, in §4.1.4, insert “persons” prior to “employed” and merge the text of §4.1.1 into the main section. Consistent with the “Fourth” observation above, this results in the following:

4.1.4. persons employed or volunteering at an agency that contracts with the Department who are in a position which involves the opportunity to have direct access to a child.

Seventh, there is some “tension” between applying the background check process only to a “child care person” meeting “direct access” criteria and the categorical mandate in §4.2.1 requiring background checks by position regardless of direct contact. For example, if a groundskeeper, administrative secretary, or administrative bookkeeper is expected to have no “regular direct contact” with children, they would not be a “child care person” subject to a background check. However, §4.2.1 would manifestly require them to submit to a background check. At a minimum, DFS should consider limiting §4.2.1 to persons expected to have “regular direct access” to children.

Eighth, §7.0 is “overbroad”. For example, §7.1.1.1 contemplates consideration of arrest records without conviction. This is inconsistent with recent EEOC guidance. See attachments. Consistent with the EEOC Q&A document, Par. 7, the Enforcement Guidance preempts inconsistent state laws and regulations. In the analogous context of adult criminal background checks, the DLTCRP recently adopted the following regulatory standard deferring to the EEOC guidance:

8.3. DHSS adopts the guidance from the Equal Opportunity Commission, Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964, 915.002, issued 4/25/2012.

16 DE Admin Code 3105, §8.3.

Ninth, in §10.1.1, insert a comma after the word “employer”.

Tenth, §10.2 would violate the EEOC guidance if “history of prohibited offenses” includes arrests without conviction. The immediately preceding §10.1.2 refers to “arrests” which implies that “offenses” may include arrests.

Eleventh, §10.1.2 includes a plural pronoun (“them”) with a singular antecedent (“employer”). Substitute “the employer” for “them”.

Twelfth, some sections omit punctuation. This should be corrected. See, e.g., §§8.2, 7.1.1, 4.2.1, and 6.1. The latter section has a period after §6.1.10 and no punctuation after §6.1.11.

I recommend sharing the above observations with the Division.

6. DFS Prop Child/Health Care Setting Child Abuse Registry Reg. [16 DE Reg. 1159 (May 1,2013)]

The DFS Office of Child Care Licensing is proposing to adopt revisions to its standards covering criminal background checks for individuals involved in child care, health care, and educational settings. Background is provided in the attached May 4, 2103 News Journal article.

I have the following observations.

First, the title to the regulation is “underinclusive”. It only refers to “child care and health care persons”. In contrast, the regulation also covers public school employees and volunteers. See §3.0, definitions of “conditional public school person”, “person seeking employment”, “person seeking employment with a public school”, and “public school”; and §4.1.1. The title should be expanded to highlight its coverage of educational personnel.

Second, in §1.0, I recommend substituting “Basis” for “Base” in the title.

Third, in §3.0, the definition of “child care person”, and §4.1.1 only apply the registry check process to persons who would be “alone” with children or persons in care. This should be reconsidered.

A. In Title 11 Del.C. §8563(a), the statutory definitions of “direct access”, “person seeking employment”, and “person seeking employment with a public school” are not limited to persons who would be “alone” with a child or person receiving care. Indeed, the statute [Title 11 Del.C. §8563(a)(4)] literally requires registry checks of anyone applying for work in a child care or health care setting regardless of access to children or persons receiving care. The only reference to “direct access” is in the context of public school personnel. Compare Title 11 Del.C. §8563(a)(5). If DFS defines “direct access” to only cover personnel who would be regularly “alone” with children or persons receiving care, employers may justifiably exclude many child and health care workers from the background check process. Moreover, although the statute [Title 11 Del.C. §8563(a)(4)] requires all applicants for a license to operate a child care facility to undergo a background check, the regulations would exempt such applicants if they are “off site” owners without individual access to children.

B. There are situations in which perpetrators act as a team to abuse/neglect vulnerable persons. Just because someone is not alone with a child or person receiving care, does not mean that the child or person receiving care is not at risk.

Fourth, in §7.1, there is a plural pronoun (“they”) with a singular antecedent (“person”). Consider the following revision - “When...perpetrator, they the person will be allowed...”

Fifth, the enabling statute [Title 11 Del.C. §8563(h)] authorizes other entities, including nonpublic schools, to voluntarily submit to the background check process. The regulation is completely silent in this context. This could result in confusion among employers and DFS staff when implementing the statutory authorization.

I recommend sharing the above observations with the Division.

7. DSS Food Supplement Program Time Limit Regulation [16 DE Reg. 1143 (May 1, 2013)]

The Division of Social Services proposes to revise its Food Supplement Program standards in the context of time limits for “Able-bodied adults without dependents”. The rationale is “to make the rules easier to understand and follow”, to add a federal citation, and to change the name of the section to more accurately reflect the content of the policy.

The revised regulation generally conforms to the attached federal regulation, 7 C.F.R. §273.24. The federal regulation implements a federal law limiting receipt of “food stamp” benefits to 3 months in a 36-month period for “able-bodied adults without dependents” (ABAWDs) who are not working or who are not exempt. See attached USDA summary. I recommend endorsement subject to consideration of a minor revision to §9018.2, Section 4, as follows:

Good cause includes circumstances beyond the individual’s control, such as, but not limited to: ...

This would clarify that the subsequent list is illustrative only and more closely conform to the analogous federal standard, 7 C.F.R. §273.24(b)(2).

I recommend sharing the above commentary with the Division.

8. DSAMH Prop. Mental Health Screener Regulation [16 DE Reg. 1148 (May 1, 2013)]

The Division of Substance Abuse and Mental Health proposes to adopt some discrete revisions to its mental health commitment screening standards. The rationale is that, effective July 1, only credentialed mental health screeners can authorize a mental health commitment-related detention. See Title 16 Del.C. §§5121A and 5122. However, the current mental health screener training curriculum does not address children. Therefore, on an interim basis, DSAMH and the DPBHS would like to authorize psychiatrists and credentialed physicians (but not non-physician screeners) to authorize commitment-related detention of children. This will provide some time to modify the screener curriculum to address children. An April 26, 2013 email from DHSS summarizes this intended approach:

Concerns were also raised about how the changes enacted by HB 311 affect youth, particularly regarding the requirement that only credentialed mental health screeners can decide if someone should be held involuntarily for evaluation. Under current law, youth are evaluated under the same law as adults, thus, the new screener requirement will apply to youth as well. Because the screener curriculum did not anticipate youth, DHSS is publishing a proposed amendment to the HB 311 regulations on May 1. The amendment will allow psychiatrists and credentialed physicians to evaluate people under age 18, but other credentialed screeners may only evaluate adults. This way, if the physicians who are currently doing these evaluations for juveniles get credentialed by June 30th, we will essentially preserve the status quo for juveniles until any new process/requirements are thought through and enacted.

I recommend endorsement of this approach subject to revised language in the proposed regulation.

First, in §3.1.3, insert “Delaware-licensed” between “A” and “psychiatrist”. This would clarify, consistent with Title 16 Del.C. §5122(a)(1)a, that the authorization of a “psychiatrist” to authorize a commitment-related mental health detention does not extend to psychiatrists lacking a Delaware license.

Second, in §§3.1.3, 3.2.4, 3.3.4, 3.43, and 3.5.2, I recommend revised language.

A. The statutory term is “detention”, not detainment. See Title 16 Del.C. §5122.

B. Literally, the regulation states that the screener “detains” the individual. This is not accurate. In general, the screener authorizes detention but does not personally physically detain the individual. The screener’s certification authorizes designated transport personnel, including police, to “detain” and transport the individual. See Title 16 Del.C. §5122(d) and 5122(a)(6).

C. The relevant statutes do not authorize a screener to “abrogate” a detention or detainment. Once the authorized screener completes the detention form, designated transport personnel promptly take the person to a treatment facility. See Title 16 Del.C. §5122(d). Once there, an independent psychiatrist assesses the patient within 24-72 hours and either discharges the patient forthwith or initiates the involuntary commitment process. See Title 16 Del.C. §5122(f)(g). Indeed, in the case of minors, a DSCY&F designated psychiatrist is authorized to independently determine if a detained minor meets admission criteria. See Title 16 Del.C. §5122(h). Contrary to the proposed regulation, the “screener” cannot rescind a form after formal issuance. This could result in conflicts between the screener and the facility psychiatrist. For example, if the screener “abrogates a detainment” after an individual has arrived at a facility, and the facility staff disagree, whose view controls?

Therefore, I recommend that the above references be changed to “may authorize detention for a psychiatric evaluation”.

I recommend sharing the above observations with the Division as well as the DPBHS and the DHSS Chief Policy Advisory, Deborah Gottschalk.

9. DLTCRP Prop. LTC Transfer, Discharge & Readmission Reg. [16 DE Reg. 1130 (May 1, 2013)]

The Division of Long-term Care Residents Protection proposes to adopt a “complete revision” of its standards covering transfers and discharges from long-term care facilities.

I have the following observations.

First, Section 1.2 contains the following exclusion:

This regulation does not extend to decisions of DHSS or any of its Divisions, to deny, suspend, delay, reduce or terminate benefits. The regulation governing appeals related to benefit eligibility are found at 16 DE Admin Code §5000.

This exclusion is highly problematic.

The “5000” series regulation recites that it only applies to DMMA and DSS. See 16 DE Admin Code 5000, §5001. Thus, if a non-Medicaid resident of a DHSS-run nursing facility, (GBHC; Bissell; DHCI) were being discharged, the resident would have no right to an impartial hearing under Title 16 Del.C. §1121(18) or the “5000” series. Likewise, a resident of a DSAMH-sponsored group home would have no right to an impartial hearing under §1121(18) or the “5000” series. A non-waiver DDDS resident of a group home or shared living/adult foster home would have no right to an impartial hearing under §1121(18) or the “5000” series. The purported exclusion is inconsistent with the §1121(18). Conversely, a Medicaid-funded nursing facility resident is not limited to the DLTCRP 3102 regulation to contest a discharge/transfer. Under federal law and DHSS regulation, such an individual is entitled to a hearing from the Medicaid agency to contest a nursing facility discharge/transfer. See 42 C.F.R. §431.206(b)(3) and §431.201(a) and 16 DE Admin Code 5000, §5001, Par. 2.C. Section 1.1 of the proposed regulation suggests that the DLTCRP 3102 regulation is the exclusive hearing system for appeals of LTC facility discharges/transfers. There is no analog to §4.6.2 (covering Medicare-funded residents) for Medicaid-funded residents of nursing facilities.

Second, in §2.0, definition of “facility”, I recommend simply cross referencing Title 16 Del.C. §1102(4). If the full text is retained, the Division should substitute “Title 16” for “this title”.

Third, §3.1.1.5 could be improved to better address episodic conditions or those subject to remission and flare-ups. If someone’s condition has temporarily improved, this should not be the basis for discharge. Consider amending the reference to “...services provided by the facility on a long-term basis”.

Fourth, in §3.2.1.3, the reference to “treatment team” is problematic. There is no definition of “treatment team” and some facilities (e.g. shared living/foster home) may lack a “treatment team”.

Fifth, in §3.3.1, consider the following revision: “(b)efore a facility ~~transfers or discharges~~ proposes to transfer or discharge a resident...” This would be more consistent with the 30-day advance notice requirement in §3.3.2.1.

Sixth, there is some “tension” between the definition of “transfer and discharge” in §2.0 (limiting “transfer” to movement outside the facility) and use of the word “transfer” in §§3.3.2.2.2 and 3.6.1.1 in the context of intra-facility changes of roommates.

Seventh, in §3.3.3.1.3.1, substitute “facility’s” for “facilities”.

Eighth, in §3.3.3.1.7.6, consider deletion of “nursing”. Compare §3.3.1.2.

Ninth, in both §§3.7.2.1 and 3.7.2.2, delete the term “nursing”.

Tenth, there is some “tension” between §3.3.3.1.7 and 4.1.2.3. A facility’s attorney could argue that a resident who submits a timely hearing request to the DLTCRP, but does not “copy” the facility or Ombudsman, has not “perfected” an appeal. Indeed, §3.3.3.1.7 does not specifically include the requirement to “copy” the facility and Ombudsman in the facility notice so a resident may not be aware of the requirement. The DLTCRP has previously shared its view that “copying” the Ombudsman and facility is “directory” and not a basis for dismissal of an appeal. However, the regulation should be revised for clarity. Consider the following revision: “Copied to the facility and the State LTC ombudsman; provided that delay in providing a copy shall not result in denial or dismissal of a hearing request.”

Eleventh, §4.6.1.1 contains an “unusual” right for the facility to inspect the resident’s records. This is not the general DHSS approach. Compare 16 DE Admin Code 5000, §5311E and F and §5403. I recommend substitution of the following in §4.6.1.1: “Complete any inspection and duplication of records pursuant to a request under Title 16 Del.C. §1121(19).”

I recommend sharing the above observations with the Division.

10. DMMA Prop. Diamond State Health Plan Renewal Notice [16 DE Reg. 1140 (May 1, 2013)]

The Division of Medicaid and Medical Assistance has issued a notice soliciting comments on its proposed renewal of the Diamond State Health Plan (DSHP) waiver. The notice includes links to a 61-page document [hereinafter “Extension Request”] containing the proposed waiver application and several appendices. The DSHP is the Medicaid managed care program first adopted in 1996. The Extension Request (p. 61) indicates that comments and the DMMA responses will be shared with CMS.

I have the following observations.

First, the Public Notice is inconsistent with the “Extension Request”. The Notice [16 DE Reg. 1140 (May 1, 2013)] recites that the extension is sought “for an additional three years”. In contrast, the Extension Request is for five years. At pp. 4 and 61.

Second, the Division of Prevention and Behavioral Health Services (DPBHS), formerly the Division of Child Mental Health Services, was identified as a distinct MCO under the original DSHP. See attachments. If it still enjoys that status, its role should be described in the Extension Request. The Extension Request (p. 15) indicates that “extended mental health” benefits “are covered under the traditional Medicaid system.” To the contrary, my impression is that the DPBHS provides extended mental health benefits for children enrolled in the DSHP requiring more than a certain threshold of services.

Third, on p. 7, the word “thought” should be “through”.

Fourth, effective July 1, 2014, DMMA “plans to terminate the state-operated primary case management entity, Diamond State Partners (DSP).” See Extension Request, p. 12. The DSHP originally had four MCOs. By 2002, it had only one MCO left. See Extension Request, pp. 22-23. Given the need for “choice”, DMMA essentially established a State MCO, Diamond State Partners (DSP). From 2007 to the present, DMMA has had two private MCOs. DMMA implies that enrollment in DSP has declined dramatically due to the attractiveness of the two private MCOs:

DSP was created in July, 2002 when Delaware had only one commercial Managed Care Organization (MCO). However, since 2007, Delaware has had two viable commercial MCOs for member choice. As a result, DSP enrollment has dropped from a high enrollment number of 17,980 in May, 2004 to less than 3,200 currently.

Enrollment Request, p. 12.

In fact, DMMA has discouraged or barred recent enrollment in DSP. In 2011, when the waiver was being modified to create the DSHP+ program, the Councils strongly objected to DMMA’s decision to bar participation of DSP. The Councils viewed a choice among only two MCOs as minimal. The Councils also stressed that the State would lose “leverage” in financial negotiations with two MCOs since the MCOs would realize that withdrawal of either MCO could force the State to create a State MCO. DMMA acknowledges this “dynamic” in the current Extension Request (at p. 23): “The decisions of various MCOs to discontinue participation in the DSHP in the past were based largely on their attempts to negotiate exorbitant inflationary increases at contract negotiation time, believing that Delaware would have to accept their terms or discontinue the waiver.” In pertinent part, my September 2, 2011 (italicized) critique of the DSHP+ proposal was as follows:

CHAPTER II: PROGRAM DESCRIPTION

Section II.1: This section recites that “(t)he State wishes to have a maximum of two Contractors to provide a statewide managed care service delivery system...”. This is apart from the State-run MCO, Diamond State Partners (DSP) which DHSS notes is closed to new members. See also §II.3.3. There are multiple “concerns” with this approach.

a. The Division of Prevention and Behavioral Health Services (DPBHS) is an MCO under the DSHP. This is not clarified in this section or elsewhere in the document. Section II.7.6.2.1, which uses outdated references to the Division of Child Mental Health Services, does not identify DPBHS as an MCO under the DSHP. Parenthetically, an outdated reference to DCMHS also appears in §9.5.2.

b. Allowing only the 2 current private MCOs to implement the DSHP Plus severely limits participant freedom of choice. The original DSHP had four (4) MCOs - Amerihealth, Blue Cross, First State, and Delaware Care. This provided real competition and an incentive to offer supplemental services (e.g. eyeglasses) to attract participants. Although the current plan authorizes MCOs to offer supplemental services (§§II.7.3.1.a; 7.3.3; and 7.5, final bullet), the prospects for MCOs offering such services are marginal given the non-competitive system adopted by DHSS. The prospects for “conscious parallelism”, “price fixing”, and collusion are enhanced with only 2 MCOs. No RFP was issued to invite competitive bids to serve as an MCO. Moreover, DHSS eschews any negotiating leverage with the 2 approved MCOs which are quite aware of the burden faced by DHSS if 1 of the MCOs withdraws. The Concept Paper contains the following recitation:

(I)n the unlikely event that one MCO should discontinue participation in DSHP Plus, DMMA requests authority to continue mandatory managed care for up to 15 months under a single MCO while DMMA seeks participation from a second qualified MCO.

This undermines the important “choice” feature of the Medicaid program and merits opposition. Moreover, given the history of MCO’s dropping out of the DSHP, the representation that discontinuation of participation by 1 MCO is an “unlikely event” is not realistic. The only reason DHSS established a State-run MCO was because MCOs cited monetary losses, dropped out of the DSHP, and left only one private MCO.

It would be preferable to include DSP as an MCO implementing DSHP Plus or to issue an RFP to enroll more than 2 private MCOs.

I recommend strong opposition to discontinuation of the DSP. I also recommend that DMMA provide satisfaction survey results on DSP to permit comparison with satisfaction survey results from the two private MCOs described at p. 38 of the Extension Request. If satisfaction results for the DSP are high, this would provide additional support for not diminishing “choice” by terminating the DSP.

Fifth, DMMA describes case management as follows:

DMMA has established minimum case management program requirements and qualifications for case managers. ...Additionally, DMMA requires that each MCO assign one and only one case manager for every member eligible to receive long-term care services.

Extension Request, p. 15.

The Councils have shared concerns with case manager-participant ratios under the DSPH+ and the lack of specialized expertise among case managers for distinct subpopulations, particularly TBI. Details could be shared on request.

Sixth, the planned expansion of eligibility to individuals with countable income at or below 133% of the FPL merits endorsement. See Extension Report at p. 12. However, it would also be preferable if the benefits menu could be enhanced to cover adult dental services. Such services are currently excluded. See Extension Request at p. 16. Such expansion has some legislative support. See S.B. No. 56, introduced on April 30, 2013.

Seventh, DMMA indicates that its Health Benefits Manager (HBM) “encourages”, members of the same family to select the same MCO. The rationale for such “encouragement” is not disclosed. “Steering” of participants to a single MCO based on the choice of other family members is ostensibly an odd approach. It would be preferable to prioritize other factors, including whether the MCO includes the PCP and specialist used by the participant.

Eighth, on p. 29 of the Extension Request, the reference to “QII lead by DMMA” merits revision.

Ninth, p. 38 of the Extension Request contains the following recital: “Results indicate that provider satisfaction levels during this period 2009 to 2012 are positive in both plans. “ This is somewhat cryptic since a 51% satisfaction rating could be viewed as “positive”. It would be preferable to provide more specific results. Consistent with the “Fourth” comment above, it would also be useful to include satisfaction statistics for the DSP.

Tenth, the restriction to change MCOs to once annually (Extension Report, p. 60) should be subject to exceptions for cause. Indeed, Attachment “D”, which collects client complaints, describes a request to change an MCO since the PCP was no longer enrolled with the current MCO. It should be regarded as “good cause” to switch to an MCO in which the PCP is a participating provider.

Eleventh, the Extension Report, p. 60, recites as follows: “DSHP applicants are always approved retroactively to the first of the month in which they apply for coverage if they meet all Medicaid qualifying criteria”. I question the accuracy of this representation. The DLP is currently involved in a case in which DMMA has declined retroactive eligibility to the first of the month in which the applicant applied for coverage. DMMA identifies the first of the month in which the participant enrolls with an MCO as the initial date of coverage. Moreover, the attached excerpt from the March, 22, 2012 CMS approval of the DSHP identified a concern with 6-8 week delays in initiating Medicaid eligibility for approved applicants.

Twelfth, Attachment P, Table IV, Goal 4, establishes a benchmark of “number and percent of members who rate their experience of care as ‘Good’ or ‘Very Good’.” This could be improved. For example, if the only 2 choices are “Good” and “Very Good”, the results are not valid. The other categories in the survey (e.g. poor; fair; excellent) should be identified.

Thirteenth, Attachment P, Table IV, Goal 1, includes a quality measure based on “appeals both pre-service and post-service per 1,000 members”. The Councils have expressed concern with the negligible number of appeals of DSHP+ participants. Based on participant descriptions of proposed reductions in services without MCO disclosure of appeal rights, this measure may be of questionable validity. Moreover, it would be preferable if DMMA would honor CLASI’s request to require contact information about the availability of free legal assistance in MCO notice forms.

I recommend sharing the above observations with DMMA.

11. H.B. No. 89 (Rehabilitation Hospital Exemption from Del. Health Resources Bd. Review)

This legislation was introduced on April 24, 2013. As of May 6, it remained in the House Health & Human Development Committee.

Background is as follows.

In approximately 2011, HealthSouth initiated efforts to obtain necessary government approvals to construct a 34-bed free-standing rehabilitation hospital in Middletown. The focus of treatment would be traumatic and non-traumatic brain injury and spinal cord injury. Consistent with the attached October 8, 2011 article, the City of Middletown approved the building plans. HealthSouth presented its proposal to the SCPD and the SCPD submitted the attached March 17, 2011 comments to the Board in support of the facility. However, consistent with the attached April 29, 2013 News Journal article, the project was initially disapproved by the Delaware Health Resources Board based on its view that the proposal would likely lead to “overbuilding” and unnecessary health care billing. Board membership then changed based on resignations and appointments of new members by the Governor. The newly constituted Board approved the application. The operator of a Middletown nursing facility then initiated litigation to overturn the Board’s approval. That litigation is still pending.

H.B. No. 89 would exempt any “freestanding inpatient rehabilitation hospital” from review by the Delaware Health Resources Board and potentially moot the pending litigation. There are pros and cons to the bill.

On the one hand, the SCPD remains supportive of expanding access to specialized treatment for TBI and other conditions without having to travel out-of-state. Moreover, opposition to the proposed hospital is not emanating from individuals with treatment needs; it is emanating from a financial competitor.

On the other hand, exempting rehabilitation hospitals from the “certificate of need” process is conceptually troublesome. A compromise approach would be for the litigants to simply stipulate to a rehearing by the Board to reduce prospects for protracted delays attributable to continued litigation.

I recommend that the Council share its March 17 letter endorsing the proposed hospital and confirm its continued support for the initiative.

12. H.B. No. 88 (Possession of Deadly Weapons by Certain Individuals)

This legislation was introduced on April 23, 2013. As of May 6, it remained in the House Health & Human Development Committee.

Background is provided by the attached April 23 News Journal article, April 23 News Journal editorial, April 22 WDEL summary, and April 22 Associated Press article. The lengthy synopsis also provides a comprehensive analysis of the intended results of the legislation.

In nutshell, the bill seeks to expand the scope of existing laws restricting access to deadly weapons by persons with mental health profiles. This includes individuals found not guilty by reason of insanity, mentally incompetent to stand trial, or guilty but mentally ill in connection with a crime of violence (lines 13-19). It also expands the scope of agencies given immunity for reporting “dangerous” individuals to law enforcement (lines 153-155).

I have the following observations.

First, historically, studies have demonstrated that individuals with mental illness are more often victims, rather than perpetrators, of crime. The synopsis recognizes this observation: “Statistically, mental illness has little to do with homicide perpetration but conversely increases the chances of being a victim of violence.” Thus, gun rights advocates could cogently argue that persons with mental illness have more need for access to firearms for self-defense, not less need for access.

Second, the legislation does create an anomaly which may violate the federal ADA. Consistent with lines 4 and 70-71, individuals convicted of misdemeanor crimes of violence automatically regain their right to purchase and possess deadly weapons after 5 years. In contrast, individuals found not guilty by reason of insanity or found incompetent to stand trial for the identical crime would not regain their right to purchase and possess deadly weapons after 5 years. Findings of not guilty by reason of insanity and incompetency to stand trial for adults require evidence of disability. See Title 11 Del.C. §401 and 404. Moreover, these individuals have not been convicted of a crime. Therefore, it would be preferable to amend lines 70-72 as follows: “Any person...not a felony, or found incompetent to stand trial or not guilty by reason of insanity in connection with an offense which is not a felony shall not be prohibited...”.

Third, there are inconsistencies between the text of the bill and articles describing its effect. I will provide examples orally.

I recommend sharing observations “First” and “Second” with policymakers. The Council could also discuss whether to take no position on the bill or endorse the concept of the bill.

13. S.B. No. 35 (Specialty Tier Prescription Drug Coverage)

This bill was introduced on April 16, 2013. As of May 6, it remained in the Senate Health & Social Services Committee.

As background, in 2011 S.B. NO. 137 was enacted which directed the Delaware Health Care Commission to “conduct a study for specialty-tier prescription drugs to determine the impact on access and patient care.” The Commission completed its assessment and compiled the results in the attached document: “Specialty-Tier Prescription Drugs: A Report to the General Assembly” (March 15, 2012).

The Report concludes that the primary purpose of specialty tiers is to require policyholders to pay more for particularly expensive drugs. Such drugs typically target very specific medical conditions, including hemophilia, AIDS/HIV, cancer, and MS. The use of this cost-shifting strategy has become more prevalent in recent years. Rather than pay a low (e.g. \$10) fixed monetary amount (known as a co-pay), insurers generally require policyholders to pay a high (e.g. 25%) fixed percentage (known as co-insurance) for a specialty tier drug. The Commission identified one example of a hemophilia drug with a cost of \$30,000 per month subject to a 25% coinsurance contribution from the family.

S.B. No. 35 is designed to impose some standards on private insurers. The bill only allows covered insurers to charge an aggregate of copayment and coinsurance of \$100 per month for a 30 day supply of a single specialty tier drug (lines 34-35). Insurers would also be subject to a cap of \$200 monthly for aggregate copayment and coinsurance for multiple specialty tier drugs (lines 36-37). Insurers would be barred from placing all drugs in a given class on a specialty tier (lines 45-46). Policyholders could request an exception to application of tiered cost sharing with support of the prescribing physician (lines 38-44). Denials would be subject to arbitration and an appeal process (lines 43-44).

I recommend endorsement. Parenthetically, the use of “incent” in line 51 is correct based on modern dictionaries. It means the same as “incentivize”.

14. S.B. No. 56 (Medicaid Coverage of Adult Dental Services)

This legislation was introduced on April 30, 2013. As of May 6, it remained in the Senate Health & Social Services Committee.

The legislation is almost identical to S.B. No. 262 introduced in the 146th General Assembly and S.B. No. 284 introduced in the 145th General Assembly. The SCPD issued the attached June 28, 2012 letter endorsing the concept of S.B. 262. I recommend sending a similar letter while changing the reference to “endorses the concept” to an outright “endorsement”.

15. S.B. No. 51 (Teacher Preparation)

This bill was introduced on April 24, 2013. It passed the Senate unanimously with one lengthy amendment on May 2.

Background is provided in the attached April 24, 2013 and May 3, 2013 News Journal articles. In a nutshell, the legislation imposes more rigorous standards on enrollment in teacher preparation programs and requires passage of a new test to become certified. Overall, it is intended to raise the caliber of instructors in Delaware schools. Longitudinal data on graduates working in Delaware schools would be collected. The legislation is detailed and prescriptive. It has been endorsed by the DSEA.

I recommend endorsement.

16. H.B. No. 90 (Choice School Enrollment)

This legislation was introduced on April 23, 2013. As of May 6, it had been released from the House Education Committee.

In a nutshell, the bill revises many sections of the enabling law establishing the school choice program. It allows students to “choice” to a charter school. It requires the Department of Education to establish and distribute a uniform application form. It addresses acceptance standards and adds “truancy” to grounds for rejection. Finally, as amended by H.A. No. 1, it establishes a large (27 member) “Enrollment Preferences Task Force” to report findings and recommendations to the Governor and General Assembly by January 31, 2014.

I have the following observations.

First, one of the motivators for the legislation was the potential for exclusion of students with disabilities based on the following acceptance/rejection provision:

Such criteria shall include the authority of the receiving district to reject an application based upon the requirements of any applicable existing individualized education plan relating to an applicant who has special needs.

The bill deletes this provision (lines 92-94). Consistent with the attached April 9, 2013 policy letter from the U.S. Department of Education to the Wisconsin Department of Education, school choice programs cannot be administered in a manner which discriminate against students with disabilities. Moreover, states must ensure that “disability status has no unlawful adverse impact on admissions decisions”. At p. 2. While deletion of the above provision may promote compliance with federal law, schools could ostensibly continue to reject students with disabilities by requesting supplemental information such as IEPs (lines 50-51) and then deciding that the student does not meet criteria “related to the nature of the program or school” (line 90). It would be preferable to include an affirmative non-discrimination standard. For example, instead of deleting the above provision (lines 93-94), it could be modified as follows:

Such criteria shall ~~include the authority of the receiving district to reject an application~~ disallow the rejection of an application based upon the content of any applicable existing individualized education plan or Section 504 plan relating to an applicant who has special needs.

Second, although the Delaware Code has historically contemplated the potential for students using the “choice” program to apply to a charter school [Title 14 Del.C. §509(a)], the bill explicitly authorizes use of “choice” to apply to charter schools (lines 38, 52-53). However, this results in conflicts between the charter school and choice laws. The following are examples.

A. Authorized preferences are different. Compare Title 14 Del.C. §506(a)(3)(4) with lines 88-108).

B. Choice students must generally enroll for 2 years while charter students must generally enroll for 1 year. Compare Title 14 Del.C. §407(a)(2) with Title 14 Del.C. §506(d).

Third, lines 80-81 require receiving districts to offer public information sessions on choice opportunities available in schools and programs in that district. When the GACEC assessed Vo-Tech district admissions, a downstate district noted that local “regular” districts no longer allowed the Vo-Tech district to participate in similar information sessions. It would be preferable to add the following sentence to line 81: “Each reorganized receiving district will invite the participation, on a voluntary basis, of representatives of the Vo-Tech district and charter schools from the same county as the reorganized receiving district.” This would allow families to attend 1 event and receive information about more options.

I recommend sharing the above observations and recommendations with legislative policymakers and the Lt. Governor.

17. H.B. No. 105 (Election Day Voter Registration)

This bill was introduced on April 30, 2013. As of May 6, it remained in the House Administration Committee.

Background is contained in the attached excerpt from the May 3, 2013 Delaware House of Representatives e-Newsletter. The bill would make Delaware the 12th state to allow Election Day registration. A prospective voter could register by completing an application accompanied by a government issued photo identification or other document (e.g. bank statement; utility bill). Detractors of the legislation cite increased risk of voter fraud. Proponents cite facilitation of voting.

Given the prevalence of studies showing that voter fraud is rare, and the advantages of Election Day registration to individuals with disabilities, I recommend endorsement.

Attachments
8g:legreg/513bills
F:pub/bjh/legis/2013/313bills

MEMORANDUM

DATE: March 27, 2013

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 16 DE Reg. 921 [DMMA Proposed Increased Medicaid Primary Care Service
Payment Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposal to amend the Medicaid State Plan to conform to changes prompted by the federal Affordable Care Act. The proposed regulation was published as 16 DE Reg. 921 in the March 1, 2013 issue of the Register of Regulations.

In a nutshell, states are required to adjust Medicaid payment rates for certain primary care services in 2013 and 2014 to ensure that they at least match certain Medicare rates. States are also required to adjust fees for vaccine administration under the Vaccines for Children (VFC) program to match the greater of a Medicare rate and VFC regional maximum amount. The federal government will cover 100% of the costs of the difference between the current State payment rates and the new rates so there is no State fiscal impact.

SCPD endorses the proposed regulation since the changes are required to conform to federal law and CMS guidance.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our position on the proposed regulation.

cc: Mr. Stephen Groff
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

**GOVERNOR'S ADVISORY COUNCIL FOR EXCEPTIONAL CITIZENS**

GEORGE V. MASSEY STATION
516 WEST LOOCKERMAN STREET
DOVER, DELAWARE 19904
TELEPHONE: (302) 739-4553
FAX: (302) 739-6126

February 27, 2013

Deborah Harvey
Division of Public Health
417 Federal Street
Dover, DE 19901

RE: DPH Proposed Newborn Screening Regulation [16 DE Reg. 827 (February 1, 2013)]

Dear Ms. Harvey:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the Division of Public Health (DPH) proposal to adopt extensive revisions to its regulation covering screening of newborn infants for metabolic, hematologic, endocrinologic and certain structural disorders. The GACEC would like to share the following observations.

First, in §1.0, the original regulation contained a second "sentence" beginning "(T)hese regulations describe...". The superseding revision is grammatically incorrect. It is not a sentence: "To regulate the procedures for the Newborn Screening Program where each newborn delivered in the state must be provided a panel of screening tests to identify certain metabolic, hematologic, endocrinologic and certain structural disorders that may result in developmental delay, cognitive disabilities, serious medical conditions, or death."

Second, in the same "sentence", Council recommends deletion of the word "certain" between "identify" and "metabolic". Compare comparable provisions in title to §4.0, §4.1, and 6.1. The definitions of "endocrinologic disorder", "hematologic disorder", and "metabolic disorder" are not restrictive. Indeed, the definition of "metabolic disorder" refers to "include, but are not limited to...".

Third, the regulation sometimes refers to an "institution" and sometimes refers to a "facility". The term "institution" is used in §§1.0, 5.2, 7.2, 9.1, 9.2, and 10.1. The term "facility" is used in §§1.0, 4.1.1, 4.3, 6.1.1, 6.1.3, 6.2, and 6.3.1. The Delaware Manual for Drafting Regulations issued by the Register of Regulations offers the following guidance:

6.2.2. Strive for consistency in terminology, expression and arrangement. Avoid using the same word or term in more than one sense. Conversely, avoid using different words to denote the same idea. ...

The GACEC recommends using the term "facility".

Fourth, in §2.0, definition of "hematologic disorder", the term "result" should be "results".

Fifth, the structure of §4.0 merits overhaul. Both §§4.1 and 4.3 purport to establish a sequence of responsibility for assuring collection and submission of results. Both sections contemplate parental responsibility. Council queries whether a parent of a child born in a hospital should be made responsible for collection and submission of results if "overlooked" by the hospital. Section 4.1 covers hospitals and non-hospitals. Section 4.3 overlaps, covering non-hospitals. An undefined "primary care provider" is made responsible before a parent or guardian. Thus, a grandparent providing most general care for an infant would be responsible for ensuring the screening before a parent or legal guardian. The Council suspects the Division intended to refer to "primary health care provider". Compare §8.3.

Sixth, §6.1.1 refers to "no later than 3 days after birth..." The strikeout of "3" results in a confusing reference.

Seventh, in §7.1, some words are ostensibly missing from the following sentence: "The sample must be taken from every newborn who one or more of the following categories:..."

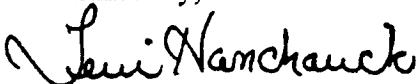
Eighth, in §7.1 and §7.2 – 'hospital/institution of birth/hospital – one of the 'hospitals' is redundant.

Ninth, in §7.1.2, there is a typographical error on the second line, "designated unsatisfactory" by the laboratory. The quotation marks should be around "unsatisfactory". The hyphen before 'by' may be the continuation of a strikethrough section and should be clarified.

Tenth, §11.0 refers only to "Hereditary Disorders". This may not be co-extensive with "metabolic, hematologic, endocrinologic, and certain structural disorders". It is unclear if abnormalities in any of these contexts could be non-hereditary (e.g. induced by oxygen deprivation during birth). If so, the reference to "Hereditary Disorders" may be too narrow.

Thank you for your time and consideration of our comments and recommendations. Please feel free to contact me or Wendy Strauss should you have any questions.

Sincerely,



Terri A. Hancharick
Chairperson

TAH:kpc



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
MARGARET M. O'NEILL BUILDING
410 FEDERAL STREET, SUITE 1
DOVER, DE 19901

VOICE: (302) 739-3620
TTY/TDD: (302) 739-3699
FAX: (302) 739-6704

MEMORANDUM

DATE: March 28, 2013

TO: Ms. Sharon L. Summers, DSS
Policy, Program & Development Unit

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 16 DE Reg. 927 [DSS Proposed Case Administration Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Social Services' (DSS) proposal to revise a variety of sections in its DSS Manual in the context of Case Administration. The changes cover many forms of public assistance and amends sections dealing with discrimination, access to records, and complaints. The proposed regulation was published as 16 DE Reg. 927 in the March 1, 2013 issue of the Register of Regulations. SCPD has the following observations.

First, §1003.4 authorizes agency staff to release records to a court-appointed guardian ad litem "relating to the child and his or her family or guardian". This may be "overbroad". The relevant statute, 29 Del.C. §9007A, confers a right "to inspect and copy any records relating to the child and parents involved in the case of appointment". This access right would not ostensibly extend to the entire "family", including siblings, aunts and uncles, etc.

Second, §1003.5 authorizes release of confidential information in connection with "civil proceedings". This is also "overbroad" and could result in disclosure of information unauthorized by law. Section 1003.5 is based on 45 C.F.R. 205.50(a) and 7 C.F.R. 272.1(c). The latter regulation does not authorize disclosure in connection with "civil proceedings". The former regulation (§205.50) authorizes release based on "any investigation, prosecution, or criminal or civil proceedings conducted in connection with the administration of any such plans or programs." Thus, if the State instituted a civil action to recover the value of benefits fraudulently obtained, access to records would be authorized. Section 1003.5, Par. 1, on the other hand, literally authorizes release of information in connection with any civil proceedings (e.g. child custody; creditor-debtor litigation; landlord-tenant litigation) which are not "connected" to the administration of the DHSS plans or programs. The references should

preferably be modified to incorporate this limitation.

Third, §1004 authorizes "sending" of records only via Division employee or Department mail. The Division may wish to consider addressing electronic forwarding of records (e.g. by encrypted or non-encrypted email). The Division may also wish to include some standards concerning safeguarding of electronic case records.

Fourth, §1005, Pars. 3 and 5 contain some inconsistent standards.

A. Par. 3.A. establishes a 5 year record retention period for records but Par. 3.D. refers to retention "beyond the three-year period".

B. Par. 3.A. establishes a 5 year record retention period but Par. 5 authorizes files to be purged after 4 years.

Fifth, §1006.1, Par. 2, states that "(n)either the Division nor its contractors will not discriminate..." The word "not" should be deleted so the statement would recite that neither the Division nor its contractors will discriminate..."

Sixth, §1008 only contemplates access to policy manuals at physical sites (e.g. public libraries; State Offices). DSS should review Title 29 Del.C. §10003 which contemplates that each agency will maintain a web portal through which FOIA requests can be made. Requests for access to records can also be made via email or fax. Section 1008 is ostensibly outdated insofar as it only describes access to information by visiting "bricks and mortar" sites. The above statute also contains specific photocopying fees information, including copying the first 20 pages for free. In contrast, §1008, Par. 3.B states that all pages are charged at a set rate.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations on the proposed regulation.

cc: Ms. Elaine Archangelo
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

16reg927 dss-case admin 3-27-13

MEMORANDUM

DATE: March 27, 2013

TO: Kai-Stefan Fountain
Division of Developmental Disabilities Services

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 16 DE Reg. 918 [DDDS Proposed Autism Services Providers Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Developmental Disabilities Services' (DDDS) proposal to implement the requirements of S.B. 22 which was enacted in 2012. It requires the Department of Health & Social Services to promulgate regulations establishing standards for certifying qualified autism services providers. The proposed regulation was published as 16 DE Reg. 918 in the March 1, 2013 issue of the Register of Regulations. As background, in early February, the Disabilities Law Program (DLP), Autism Delaware and the SCPD submitted comments on a prepublication draft of the standards. The Department is now formally publishing its proposed regulations which include some edits prompted by the earlier commentary. SCPD has the following observations.

First, in §2.0, the definition of "applied behavior analysis" is not coterminous with the statutory definition. The regulation adds two sentences which limit the scope of ABA and amount to an invitation to insurers to deny payment based on the exclusions and limitations. It is improper to have a regulatory definition which is narrower than a statutory definition. The enabling legislation does not confer authority on DHSS to further define ABA and the attempt is "ultra vires".

Second, in §2.0, the definition of "autism services provider" covers a "board certified behavior analyst" (BCBA) but omits a Board Certified Behavior Analyst Doctoral (BCBA-D) which is treated as a distinct provider throughout the regulations. See, e.g. §2.0, definition of "behavioral technician" and §§3.1, 3.2, and 4.1.1. A reference to the BCBA-D should be added to the definition of "autism services provider".

Third, in §2.0, definition of "autism services provider", the reference to "authorized by this section" is copied directly from the statute and makes no sense in the context of §2.0 of the regulations. Consider substituting "by this regulation" or, based on the reference to "these regulations" in the definition of "behavioral technician", substitute "these regulations".

Fourth, in §2.0, definition of "therapeutic care", insert "acting" between "assistant" and "under" Compare comparable reference in definition of "psychological care".

Fifth, in §3.1, first sentence, delete “to be” since the regulation(s) are establishing the standards now, not in the future.

Sixth, in §3.1, second sentence, substitute “it certifies” for “they certify” since the antecedent (Board) is singular.

Seventh, in §3.1, referring to a website that may change in a regulation may be imprudent. It would be preferable to simply refer to the most recent ethical and practice standards adopted by the Behavior Analyst Certification Board. For example, in §2.0, definition of autism spectrum disorders”, the reference is to the most recent edition of the DSM, not a version appearing on a website.

Eighth, in §3.2, the reference to “2.2” should be “§2.0”.

Ninth, in §3.3.1, first sentence, substitute “reflects” or “must reflect” for “should reflect”. The word “should” is hortatory. Cf. Delaware Administrative Code Style Manual, §6.3.

Tenth, in §3.3.1, second sentence, substitute “hours per week” for “hours a week”. Compare reference in §3.3.2.

Eleventh, in §3.3.1, second sentence, substitute “clinical management and case supervision” for “supervision” for consistency.

Twelfth, §§3.3.1 and 3.3.2 are ostensibly inconsistent. Section 3.3.1 establishes a 1.5/10 hourly ratio of supervision to treatment. Thus, a supervisor could spend 0.75 hours supervising a technician conducting 5 hours of treatment. Section 3.3.2, however, would literally require a supervisor to spend 1.5 hours in supervision for a technician conducting 5 hours of treatment. Indeed, the reference to “10 hours per week or less” results in the need to spend 1.5 hours in supervision for a technician spending 1 minute to 9.99 hours in direct treatment.

Thirteenth, §3.3.3 refers to “other requirements” It would be preferable to clarify that this applies to behavioral technicians”.

Fourteenth, in §3.3.3.7, first sentence, delete the period after “BCBA”.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations on the proposed regulation.

cc: Ms. Jane Gallivan
Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

16reg918 ddds-autism service providers 327-13

Criminal background check policy updated

EEOC issues new hiring guidelines for employers

By **SAM HANANEL**

Associated Press

WASHINGTON — Is an arrest in a barroom brawl 20 years ago a job disqualifier?

Not necessarily, the government said Wednesday in new guidelines on how employers can avoid running afoul of laws prohibiting job discrimination.

The Equal Employment Opportunity Commission's updated policy on criminal background checks is part of an effort to rein in practices that can limit job opportunities for minorities who have higher arrest and conviction rates than whites.

"You thought prison was hard, try finding a decent job when you get out," EEOC member Chai Feldblum said.

She cited Justice Department statistics showing that 1 in 3 black men and 1 in 6 Hispanic men will be incarcerated during their lifetime. That compares with 1 in 17 white men who will serve time.

"The ability of African-Americans and Hispanics to gain employment after prison is one of the paramount civil justice issues of our time," said Stuart Ishimaru, one of three Democrats on the five-member commission.

About 73 percent of employers conduct criminal background checks on all job candidates, according to a 2010 survey by the Society for Human Resource Management. Another 19 percent of employers do so only for selected job candidates.

That data often can be

inaccurate or incomplete, according to a report this month from the National Consumer Law Center.

EEOC commissioners said the growing practice has grave implications for blacks and Hispanics, who are disproportionately represented in the criminal justice system and face high rates of unemployment.

But some employers say the new policy — approved in a 4-1 vote — could make it more cumbersome and expensive to conduct background checks. Companies see the checks as a way to keep workers and customers safe, weed out unsavory workers and prevent negligent-hiring claims.

The new standards urge employers to give applicants a chance to explain a past criminal misconduct before they are rejected outright. An applicant might say the report is inaccurate or point out that the conviction was expunged. It may be completely unrelated to the job, or a former convict may show he's been fully rehabilitated.

The EEOC also recommends that employers stop asking about past convictions on job applications. And it says an arrest without a conviction is not generally an acceptable reason to deny employment.

The guidelines are the first attempt since 1990 to update the commission's policy on criminal background checks.

While the guidance does not have the force of regulations — and may conflict with state requirements for some job applicants — it sets a higher bar in explaining how businesses can avoid violating the law.

"It's going to be much more burdensome," said Pamela Devata, a Chicago employment lawyer who has represented companies trying to comply with EEOC's requirements.



U.S. Equal Employment Opportunity Commission

Questions and Answers About the EEOC's Enforcement Guidance on the Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII

On April 25, 2012, the U.S. Equal Employment Opportunity Commission (EEOC or Commission) issued its *Enforcement Guidance on the Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964*, as amended, 42 U.S.C. § 2000e. The Guidance consolidates and supersedes the Commission's 1987 and 1990 policy statements on this issue as well as the discussion on this issue in Section VI.B.2 of the Race & Color Discrimination Compliance Manual Chapter. It is designed to be a resource for employers, employment agencies, and unions covered by Title VII; for applicants and employees; and for EEOC enforcement staff.

1. How is Title VII relevant to the use of criminal history information?

There are two ways in which an employer's use of criminal history information may violate Title VII. First, Title VII prohibits employers from treating job applicants with the same criminal records differently because of their race, color, religion, sex, or national origin ("disparate treatment discrimination").

Second, even where employers apply criminal record exclusions uniformly, the exclusions may still operate to disproportionately and unjustifiably exclude people of a particular race or national origin ("disparate impact discrimination"). If the employer does not show that such an exclusion is "job related and consistent with business necessity" for the position in question, the exclusion is unlawful under Title VII.

2. Does Title VII prohibit employers from obtaining criminal background reports about job applicants or employees?

No. Title VII does not regulate the acquisition of criminal history information. However, another federal law, the Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq. (FCRA), does establish several procedures for employers to follow when they obtain criminal history information from third-party consumer reporting agencies. In addition, some state laws provide protections to individuals related to criminal history inquiries by employers.

3. Is it a new idea to apply Title VII to the use of criminal history information?

No. The Commission has investigated and decided Title VII charges from individuals challenging the discriminatory use of criminal history information since at least 1969,¹ and several federal courts have analyzed Title VII as applied to criminal record exclusions over the past thirty years. Moreover, the EEOC issued three policy statements on this issue in 1987 and 1990, and also referenced it in its 2006 Race and Color Discrimination Compliance Manual Chapter. Finally, in 2008, the Commission's E-RACE (Eradicating Racism and Colorism from Employment) Initiative identified criminal record exclusions as one of the employment barriers that are linked to race and color discrimination in the workplace. Thus, applying Title VII analysis to the use of criminal history information in employment decisions is well-established.

4. Why did the EEOC decide to update its policy statements on this issue?

In the twenty years since the Commission issued its three policy statements, the Civil Rights Act of 1991 codified Title VII disparate impact analysis, and technology made criminal history information much more accessible to employers.

The Commission also began to re-evaluate its three policy statements after the Third Circuit Court of Appeals noted in its 2007 *EI v. Southeastern Pennsylvania Transportation Authority*² decision that the Commission should provide in-depth legal analysis and updated research on this issue. Since then, the Commission has examined social science and criminological research, court decisions, and information about various state and federal laws, among other information, to further assess the impact of using criminal records in employment decisions.

5. Did the Commission receive input from its stakeholders on this topic?

Yes. The Commission held public meetings in November 2008 and July 2011 on the use of criminal history information in employment decisions at which witnesses representing employers, individuals with criminal records, and other federal agencies testified. The Commission received and reviewed approximately 300 public comments that responded to topics discussed during the July 2011 meeting. Prominent organizational commenters included the NAACP, the U.S. Chamber of Commerce, the Society for Human Resources Management, the Leadership Conference on Civil and Human Rights, the American Insurance Association, the Retail Industry Leaders Association, the Public Defender Service for the District of Columbia, the National Association of Professional Background Screeners, and the D.C. Prisoners' Project.

6. Is the Commission changing its fundamental positions on Title VII and criminal record exclusions with this Enforcement Guidance?

No. The Commission will continue its longstanding policy approach in this area:

- The fact of an arrest does not establish that criminal conduct has occurred. Arrest records are not probative of criminal conduct, as stated in the Commission's 1990 policy statement on Arrest Records. However, an employer may act based on evidence of conduct that disqualifies an individual for a particular position.
- Convictions are considered reliable evidence that the underlying criminal conduct occurred, as noted in the Commission's 1987 policy statement on Conviction Records.
- National data supports a finding that criminal record exclusions have a disparate impact based on race and national origin. The national data provides a basis for the Commission to investigate Title VII disparate impact charges challenging criminal record exclusions.
- A policy or practice that excludes everyone with a criminal record from employment will not be job related and consistent with business necessity and therefore will violate Title VII, unless it is required by federal law.

7. How does the Enforcement Guidance differ from the EEOC's earlier policy statements?

The Enforcement Guidance provides more in-depth analysis compared to the 1987 and 1990 policy documents in several respects.

- The Enforcement Guidance discusses disparate treatment analysis in more detail, and gives examples of situations where applicants with the same qualifications and criminal records are treated differently because of their race or national origin in violation of Title VII.
- The Enforcement Guidance explains the legal origin of disparate impact analysis, starting with the 1971 Supreme Court decision in *Griggs v. Duke Power Company*, 401 U.S. 424 (1971), continuing to subsequent Supreme Court decisions, the Civil Rights Act of 1991 (codifying disparate impact), and the Eighth and Third Circuit Court of Appeals' decisions applying disparate impact analysis to criminal record exclusions.
- The Enforcement Guidance explains how the EEOC analyzes the "job related and consistent with business necessity" standard for criminal record exclusions, and provides hypothetical examples interpreting the standard.
 - There are two circumstances in which the Commission believes employers may consistently meet the "job related and consistent with business necessity" defense:
 - The employer validates the criminal conduct exclusion for the position in question in light of the Uniform Guidelines on Employee Selection Procedures (if there is data or analysis about criminal conduct as related to subsequent work performance or behaviors); or
 - The employer develops a targeted screen considering at least the nature of the crime, the time elapsed, and the nature of the job (the three factors identified by the court in *Green v. Missouri Pacific Railroad*, 549 F.2d 1158 (8th Cir. 1977)). The employer's policy then provides an opportunity for an individualized assessment for those people identified by the screen, to determine if the policy as applied is job related and consistent with business necessity. (Although Title VII does not require individualized assessment in all circumstances, the use of a screen that does not include individualized assessment is more likely to violate Title VII.)
- The Enforcement Guidance states that federal laws and regulations that restrict or prohibit employing individuals with certain criminal records provide a defense to a Title VII claim.
- The Enforcement Guidance says that state and local laws or regulations are preempted by Title VII if they "purport[] to require or permit the doing of any act which would be an unlawful employment practice" under Title VII. 42 U.S.C. § 2000e-7.
- The Enforcement Guidance provides best practices for employers to consider when making employment decisions based on criminal records.



¹ See, e.g., EEOC Decision No. 70-43 (1969) (concluding that an employee's discharge due to the falsification of his arrest record in his employment application did not violate Title VII); EEOC Decision No. 72-1497 (1972) (challenging a criminal record exclusion policy based on "serious crimes"); EEOC Decision No. 74-89 (1974) (challenging a policy where a felony conviction was considered an adverse factor that would lead to disqualification); EEOC Decision No. 78-03 (1977) (challenging an exclusion policy based on felony or misdemeanor convictions involving moral turpitude or the use of drugs); EEOC Decision No. 78-35 (1978)

(concluding that an employee's discharge was reasonable given his pattern of criminal behavior and the severity and recentness of his criminal conduct).

² 479 F.3d 232 (3d Cir. 2007).

Baker gets rid of felon job box

Written by Andrew Staub The News Journal
Dec. 10

delawareonline.com

People with felony convictions no longer have to reveal their criminal background when applying for a non-uniform job with the city of Wilmington.

At the request of City Council, Mayor James M. Baker on Monday signed an executive order that removes a question about criminal convictions from city job applications unrelated to public safety.

The decree does not apply to the private sector.

"Many people who have had problems in the past need work and are ready to work and put their problem periods behind them," Baker said.

Such measures are known popularly throughout the country as "ban the box," a reference to the square employers require applicants to check denoting a conviction record. Wilmington's application also asked the applicant to indicate the type, date and location of the offense.

"By taking this action, we can restore hope, save money and give someone a fair chance and the opportunity to present themselves as an individual and not immediately be frowned upon because of past behavior," said Councilman Justen Wright, who pushed the idea that won unanimous support in the council.

Public-safety jobs in the police and fire departments are excluded from the order because of "obvious reasons," the city said.

The city will conduct criminal background checks only on applicants who have received a conditional job offer for a non-uniformed position, Baker said.

Previously, the city conducted checks on potential employees before an offer was made, said Samuel D. Pratcher Jr., the director of human resources.

Wright said he hopes other municipalities and businesses follow suit, and would like to see the ban expanded to include vendors doing business with Wilmington.

As of November, 43 cities and counties across the country had "banned the box," and statewide measures have been instituted in Hawaii, California, Minnesota, Colorado, New Mexico, Massachusetts and Connecticut, according to the National Law Employment Project.

In April, the federal Equal Employment Opportunity Commission updated its guidelines urging employers to eliminate "policies or practices that exclude people from employment based on any criminal record."

Baltimore removed the question regarding criminal history in 2007, while identifying "positions of trust" that require background checks. Last year, Philadelphia banned the box for public and private jobs.

Though support has been strong in Wilmington, such measures have been criticized elsewhere.

Earlier this year in Minnesota, business owners opposed expanding a statewide ban-the-box provision for public employers to the private sector.

The EEOC already protects against automatic denials of employment, said Ben Gerber, manager of energy and labor management policy for the Minnesota Chamber of Commerce.

"Primarily, we feel this is already being addressed, and it's kind of unnecessary legislation," Gerber said.

Different measures from state to state also can create an administrative burden for national employers, Gerber said. Employers, not the state, should decide whether they want to ask about a person's criminal history, he said.

The National Law Employment Project estimates 1 in 4 adults in the United States has a criminal record that would appear in a background check.

There are 5,770 people incarcerated in Delaware's four prison facilities and another 1,068 in community corrections centers, said John Painter, spokesman for the state Department of Correction.

Delaware processes about 23,000 intakes and 23,000 releases a year, Painter said. About 1,300 of released prisoners annually have served a sentence of a year or more, he said.

Locally, Wright said, he often hears stories of people who need jobs, but worry about a checkered past.

Councilwoman Hanifa Shabazz tied unemployment to crime, saying some people enter survival mode after a criminal record precludes them from a chance at being hired.

"That makes it very difficult for someone to continue to do the straight and narrow," she said.

The ban-the-box measures can streamline municipalities' background check procedures, while giving people with past convictions another chance at gainful employment, said Michelle Rodriguez, a staff attorney with the National Law Employment Project.

"So many times, that's all people want," she said. "They just want the opportunity to prove themselves."

Contact Andrew Staub at 324-2837, on Twitter @AndrewStaubTNJ or at astaub@delawareonline.com.

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» DELAWARE

Background checks could expand for department

State officials are proposing to expand criminal background checks for people working for or with the Department of Services for Children, Youth and Their Families.

The changes would require background checks on all departmental employees and volunteers. Current regulations only give the cabinet secretary discretion to require background checks for employees working in certain divisions of the department.

Officials want to require criminal background checks for step-parent adoptions. They also are proposing to expand background checks for residential child care facilities to include administrative staff.

Officials are accepting public comment on the proposed changes through the end of the month.

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7 CFR 273.24 - Time limit for able-bodied adults.

There is 1 rule appearing in the Federal Register for 7 CFR 273. Select the tab below to view, or [View eCFR \(GPO Access\)](#)

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§ 273.24

Time limit for able-bodied adults.

(a) **Definitions.** For purposes of the food stamp time limit, the terms below have the following meanings:

(1) *Fulfilling the work requirement* means:

- (i) Working 20 hours per week, averaged monthly; for purposes of this provision, 20 hours a week averaged monthly means 80 hours a month;
- (ii) Participating in and complying with the requirements of a work program 20 hours per week, as determined by the State agency;
- (iii) Any combination of working and participating in a work program for a total of 20 hours per week, as determined by the State agency; or
- (iv) Participating in and complying with a workfare program;

(2) *Working* means:

- (i) Work in exchange for money;
- (ii) Work in exchange for goods or services ("in kind" work); or
- (iii) Unpaid work, verified under standards established by the State agency.
- (iv) Any combination of paragraphs (a)(2)(i), (a)(2)(ii) and (a)(2)(iii) of this section.

(3) *Work Program* means:

- (i) A program under the Workforce Investment Act (Pub. L. 105-220);
- (ii) A program under section 236 of the Trade Act of 1974 (19 U.S.C. 2296); or
- (iii) An employment and training program, other than a job search or job search training program, operated or supervised by a State or political subdivision of a State that meets standards approved by the Governor of the State, including a program under § 273.7(f). Such a program may contain job search or job search training as a subsidiary component as long as such component is less than half the requirement.

(4) *Workfare program* means:

- (i) A program under § 273.7(m); or
- (ii) A comparable program established by a State or political subdivision of a State.

(b) **General Rule.** Individuals are not eligible to participate in the Food Stamp Program as a member of any household if the individual received food stamps for more than three countable months during any three-year period, except that individuals may be eligible for up to three additional countable months in accordance with paragraph (e) of this section.

- (1) **Countable months.** Countable months are months during which an individual receives food stamps for the full benefit month while not:

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- (i) Exempt under paragraph (c) of this section;
- (ii) Covered by a waiver under paragraph (f) of this section;
- (iii) Fulfilling the work requirement as defined in paragraph (a)(1) of this section; or
- (iv) Receiving benefits that are prorated in accordance with § 273.10.

(2) **Good cause.** As determined by the State agency, if an individual would have worked an average of 20 hours per week but missed some work for good cause, the individual shall be considered to have met the work requirement if the absence from work is temporary and the individual retains his or her job. Good cause shall include circumstances beyond the individual's control, such as, but not limited to, illness, illness of another household member requiring the presence of the member, a household emergency, or the unavailability of transportation.

(3) **Measuring the three-year period.** The State agency may measure and track the three-year period as it deems appropriate. The State agency may use either a "fixed" or "rolling" clock. If the State agency chooses to switch tracking methods it must inform FNS in writing. With respect to a State, the three-year period:

- (i) Shall be measured and tracked consistently so that individuals who are similarly situated are treated the same; and
- (ii) Shall not include any period before the earlier of November 22, 1996, or the date the State notified food stamp recipients of the application of Section 824 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104-193).

(4) **Treatment of income and resources.** The income and resources of an individual made ineligible under this paragraph (b) shall be handled in accordance with § 273.11(c)(2).

(5) **Benefits received erroneously.** If an individual subject to this section receives food stamp benefits erroneously, the State agency shall consider the benefits to have been received for purposes of this provision unless or until the individual pays it back in full.

(6) **Verification.** Verification shall be in accordance with § 273.2(f)(1) and (f)(8).

(7) **Reporting.** A change in work hours below 20 hours per week, averaged monthly, is a reportable change in accordance with § 273.12(a)(1)(viii). Regardless of the type of reporting system the State agency assigns to potential ABAWDs, the State agency must adhere to the statutory requirements of time-limited benefits for individuals who are subject to the work requirement. The State agency may opt to consider work performed in a job that was not reported according to the requirements of § 273.12 "work."

(c) **Exceptions.** The time limit does not apply to an individual if he or she is:

- (1) Under 18 or 50 years of age or older;
- (2) Determined by the State agency to be medically certified as physically or mentally unfit for employment. An individual is medically certified as physically or mentally unfit for employment if he or she:
 - (i) Is receiving temporary or permanent disability benefits issued by governmental or private sources;
 - (ii) Is obviously mentally or physically unfit for employment as determined by the State agency; or
 - (iii) If the unfitness is not obvious, provides a statement from a physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office, a licensed or certified psychologist, a social worker, or any other medical personnel the State agency determines appropriate, that he or she is physically or mentally unfit for employment.
- (3) Is a parent (natural, adoptive, or step) of a household member under age 18, even if the household member who is under 18 is not himself eligible for food stamps;
- (4) Is residing in a household where a household member is under age 18, even if the household member who is under 18 is not himself eligible for food stamps;

(5) Is otherwise exempt from work requirements under section 6(d)(2) of the Food Stamp Act, as implemented in regulations at § 273.7(b); or

(6) Is pregnant.

(d) Regaining eligibility. (1) An individual denied eligibility under paragraph (b) of this section, or who did not reapply for benefits because he was not meeting the work requirements under paragraph (b) of this section, shall regain eligibility to participate in the Food Stamp Program if, as determined by the State agency, during any 30 consecutive days, he or she:

(i) Worked 80 or more hours;

(ii) Participated in and complied with the requirements of a work program for 80 or more hours;

(iii) Any combination of work and participation in a work program for a total of 80 hours; or participated in and complied with a workfare program; or

(iv) At State agency option, verifies that he or she will meet one of the requirements in paragraphs (d)(1)(i), (d)(1)(ii), (d)(1)(iii), or (d)(1)(v) of this section, within the 30 days subsequent to application; or

(v) Becomes exempt.

(2) An individual regaining eligibility under paragraph (d)(1) of this section shall have benefits calculated as follows:

(i) For individuals regaining eligibility by working, participating in a work program, or combining hours worked and hours participating in a work program, the State agency may either prorate benefits from the day the 80 hours are completed or from the date of application, or

(ii) For individuals regaining eligibility by participating in a workfare program, and the workfare obligation is based on an estimated monthly allotment prorated back to the date of application, then the allotment issued must be prorated back to this date.

(3) There is no limit on how many times an individual may regain eligibility and subsequently maintain eligibility by meeting the work requirement.

(e) Additional three-month eligibility. An individual who regained eligibility under paragraph (d) of this section and who is no longer fulfilling the work requirement as defined in paragraph (a) of this section is eligible for a period of three consecutive countable months (as defined in paragraph (b) of this section), starting on the date the individual first notifies the State agency that he or she is no longer fulfilling the work requirement, unless the individual has been satisfying the work requirement by participating in a work or workfare program, in which case the period starts on the date the State agency notifies the individual that he or she is no longer meeting the work requirement. An individual shall not receive benefits under this paragraph (e) more than once in any three-year period.

(f) Waivers— (1) General. On the request of a State agency, FNS may waive the time limit for a group of individuals in the State if we determine that the area in which the individuals reside:

(i) Has an unemployment rate of over 10 percent; or

(ii) Does not have a sufficient number of jobs to provide employment for the individuals.

(2) **Required data.** The State agency may submit whatever data it deems appropriate to support its request. However, to support waiver requests based on unemployment rates or labor force data, States must submit data that relies on standard Bureau of Labor Statistics (BLS) data or methods. A non-exhaustive list of the kinds of data a State agency may submit follows:

(i) To support a claim of unemployment over 10 percent, a State agency may submit evidence that an area has a recent 12 month average unemployment rate over 10 percent; a recent three month average unemployment rate over 10 percent; or an historical seasonal unemployment rate over 10 percent; or

(ii) To support a claim of lack of sufficient jobs, a State may submit evidence that an area: is designated as a Labor Surplus Area (LSA) by the Department of Labor's Employment and Training Administration (ETA); is determined by the Department of Labor's Unemployment Insurance Service as qualifying for extended unemployment benefits; has a low and declining employment-to-population ratio; has a lack of jobs in declining occupations or industries; is described in an academic study or other publications as an area where there are lack of jobs; has a 24-month average unemployment rate 20 percent above the national average for the same 24-month period. This 24-month period may not be any earlier than the same 24-month period the ETA uses to designate LSAs for the current fiscal year.

(3) **Waivers that are readily approvable.** FNS will approve State agency waivers where FNS confirms:

(i) Data from the BLS or the BLS cooperating agency that shows an area has a most recent 12 month average unemployment rate over 10 percent;

(ii) Evidence that the area has been designated a Labor Surplus Area by the ETA for the current fiscal year; or

(iii) Data from the BLS or the BLS cooperating agency that an area has a 24 month average unemployment rate that exceeds the national average by 20 percent for any 24-month period no earlier than the same period the ETA uses to designate LSAs for the current fiscal year.

(4) **Effective date of certain waivers.** In areas for which the State certifies that data from the BLS or the BLS cooperating agency show a most recent 12 month average unemployment rate over 10 percent; or the area has been designated as a Labor Surplus Area by the Department of Labor's Employment and Training Administration for the current fiscal year, the State may begin to operate the waiver at the time the waiver request is submitted. FNS will contact the State if the waiver must be modified.

(5) **Duration of waiver.** In general, waivers will be approved for one year. The duration of a waiver should bear some relationship to the documentation provided in support of the waiver request. FNS will consider approving waivers for up to one year based on documentation covering a shorter period, but the State agency must show that the basis for the waiver is not a seasonal or short term aberration. We reserve the right to approve waivers for a shorter period at the State agency's request or if the data is insufficient. We reserve the right to approve a waiver for a longer period if the reasons are compelling.

(6) **Areas covered by waivers.** States may define areas to be covered by waivers. We encourage State agencies to submit data and analyses that correspond to the defined area. If corresponding data does not exist, State agencies should submit data that corresponds as closely to the area as possible.

(g) **15 percent exemptions.** (1) For the purpose of establishing the 15 percent exemption for each State agency, the following terms are defined:

(i) *Caseload* means the average monthly number of individuals receiving food stamps during the 12-month period ending the preceding June 30.

(ii) *Covered individual* means a food stamp recipient, or an applicant denied eligibility for benefits solely because he or she received food stamps during the 3 months of eligibility provided under paragraph (b) of this section, who:

(A) Is not exempt from the time limit under paragraph (c) of this section;

(B) Does not reside in an area covered by a waiver granted under paragraph (f) of this section;

(C) Is not fulfilling the work requirements as defined in paragraph (a)(1) of this section; and

(D) Is not receiving food stamp benefits under paragraph (e) of this section.

(2) Subject to paragraphs (h) and (i) of this section, a State agency may provide an exemption from the 3-month time limit of paragraph (b) of this section for covered individuals. Exemptions do not count towards a State agency's allocation if they are

provided to an individual who is otherwise exempt from the time limit during that month.

(3) For each fiscal year, a State agency may provide a number of exemptions such that the average monthly number of exemptions in effect during the fiscal year does not exceed 15 percent of the number of covered individuals in the State, as estimated by FNS, based on FY 1996 quality control data and other factors FNS deems appropriate, and adjusted by FNS to reflect changes in:

(i) The State agency's caseload; and

(ii) FNS's estimate of changes in the proportion of food stamp recipients covered by waivers granted under paragraph (f) of this section.

(4) State agencies must not discriminate against any covered individual for reasons of age, race, color, sex, disability, religious creed, national origin, or political beliefs. Such discrimination is prohibited by this part, the Food Stamp Act, the Age Discrimination Act of 1975 (Public Law 94-135), the Rehabilitation Act of 1973 (Public Law 93-112, section 504), and title VI of the Civil Rights Act of 1964 ([42 U.S.C. 2000d](#)). Enforcement action may be brought under any applicable Federal law. Title VI complaints will be processed in accord with 7 CFR part [15](#).

(h) Adjustments. FNS will make adjustments as follows:

(1) Caseload adjustments. FNS will adjust the number of exemptions estimated for a State agency under paragraph (g)(2) of this section during a fiscal year if the number of food stamp recipients in the State varies from the State's caseload by more than 10 percent, as estimated by FNS.

(2) Exemption adjustments. During each fiscal year, FNS will adjust the number of exemptions allocated to a State agency based on the number of exemptions in effect in the State for the preceding fiscal year.

(i) If the State agency does not use all of its exemptions by the end of the fiscal year, FNS will increase the estimated number of exemptions allocated to the State agency for the subsequent fiscal year by the remaining balance.

(ii) If the State agency exceeds its exemptions by the end of the fiscal year, FNS will reduce the estimated number of exemptions allocated to the State agency for the subsequent fiscal year by the corresponding number.

(i) Reporting requirement. The State agency will track the number of exemptions used each month and report this number to the regional office on a quarterly basis as an addendum to the quarterly Employment and Training Report (Form FNS-583) required by [§ 273.7\(c\)\(8\)](#).

(j) Other Program rules. Nothing in this section will make an individual eligible for food stamp benefits if the individual is not otherwise eligible for benefits under the other provisions of this part and the Food Stamp Act.

[Amdt. 379, 64 FR 48257, Sept. 3, 1999, as amended at 66 FR 4469, Jan. 17, 2001; 67 FR 41618, June 19, 2002; 71 FR 33384, June 9, 2006]



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Supplemental Nutrition Assistance Program

Able-Bodied Adults Without Dependents (ABAWDs)

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) limits the receipt of SNAP benefits to 3 months in a 3-year period for able-bodied adults without dependents (ABAWDs) who are not working, participating in, and complying with the requirements of a work program for 20 hours or more each week, or a workfare program.

Individuals are exempt from this provision if they are:

- under 18 or 50 years of age or older,
- responsible for the care of a child or incapacitated household member,
- medically certified as physically or mentally unfit for employment, pregnant, or
- already exempt from the work requirements of the Food Stamp Act.

States may request a waiver of this provision for people in areas with an unemployment rate above 10 percent or for those in an area with insufficient jobs. States also have authority to exempt individuals using the 15% exemption authorized by the Balanced Budget Act.

States frequently assign persons subject to the ABAWD restrictions to their Employment and Training (E&T) Program. While participating in this program, ABAWDs are exempt from the ABAWD restrictions. For information on the E&T program, go to the [Employment & Training](#) page.

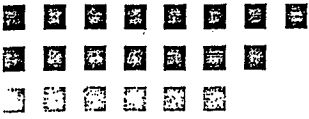
More information about ABAWDs

- [FY 2011 Allocations of the 15 percent Exemptions for Able-Bodied Adults without Dependents \(ABAWDS\) Adjusted for Carryover \(May 27, 2011\)](#)
- [SNAP ABAWD Waivers for FY 2012 \(May 3, 2011\)](#)
- [SNAP ABAWD Waivers for FY 2011](#)
- [SNAP - Statewide Able Boded Adults Without Dependent \(ABAWD\) Waivers Effective Immediately for Eligible States \(Feb. 25, 2009\)](#)
- [SNAP - ABAWD Statewide Waivers - New Criteria for Unemployment Insurance Extended Benefits Trigger \(Jan. 8, 2009\)](#)
- [2-Year Approval of Waivers of the Work Requirements for ABAWDS \(Feb. 3, 2006\)](#)
- [FY 2006 Allocations of the 15 Percent Exemptions for ABAWDS](#)
- [FY 2005 Allocations of 15% Exemptions for ABAWDs and Reporting Guidance -- Updated State Report Information](#)
- [Waiver Requests - Section 824 of PRWORA \(ABAWDs\) \(.pdf\) Gives the status of states' requests to waive the new food stamp work requirements for ABAWDs.](#)
- [ABAWD Waivers - New Method for Calculating Average Unemployment Rates \(April 22, 2004\)](#)
- [FY 2004 ABAWD Waiver Request Guidelines \(Mar. 11, 2004\)](#)
- [Adjusted Fiscal Year \(FY\) 2004 15 Percent ABAWD Exemptions \(Feb. 17, 2004\)](#)
- [Fiscal Year 2004 Allocations of 15 Percent Exemptions for ABAWDS \(Nov. 26, 2003\)](#)
- [Guidance for States on Use of Discretionary Food Stamp Program Time Limit Exemptions \(Feb. 9, 1998\)](#)
- [Guidance for States Seeking Waivers for Food Stamp Limits \(Dec. 3, 1996\)](#)
- [Transmittal Letter to Regional Administrators on Guidance to Time Limited Food Stamp Benefits \(Dec. 3, 1996\)](#)
- [Sample Letter for Regional Administrators to Send Welfare Commissioners on Guidance \(Dec. 1, 1996\)](#)

DOL Labor Surplus Area List

FY 2012 Labor Surplus Area List

EXCERPT



STATE OF DELAWARE

DIAMOND STATE HEALTH PLAN

A PUBLIC MCO INNOVATION:

**THE ROLE OF THE DIVISION OF CHILD
MENTAL HEALTH SERVICES IN MEDICAID
MANAGED CARE'S CHILD MENTAL HEALTH
PUBLIC/PRIVATE PARTNERSHIP**

February, 1996



Department of Services for
Children, Youth and Their
Families

The Waiver creates the *Diamond State Health Plan* to provide managed health care to Delaware's Medicaid-eligible population and seeks to:

- ◇ effect overall Delaware Medicaid cost containment over the life of the five year Waiver.
- ◇ increase access to care.
- ◇ deliver appropriate and timely utilization of services and
- ◇ deliver quality care efficiently.

Four managed care organizations (MCOs) have been selected to provide the basic health benefit to Medicaid-eligible individuals enrolled in the plan. They are:

- AmeriHealth First (state-wide)
- DelawareCare (state-wide)
- First State Health Plan (New Castle County only)
- Blue Cross Blue Shield Delaware (Kent and Sussex Counties only)

Included in the basic health benefit are limited mental health and substance abuse services for adults and for children. Children may receive up to 30 hours of MH/SA outpatient service.

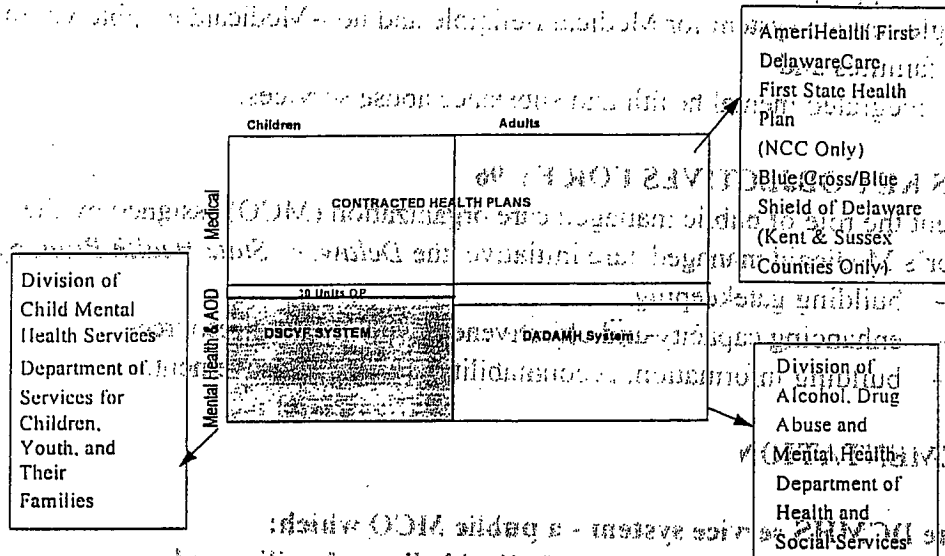
- ◇ **The role assigned by the 1115 Medicaid Waiver for the Division of Child Mental Health Services** in the Department of Services for Children, Youth and Their Families is that of a public managed care organization to partner with the private MCOs and to:
- ◇ provide for Medicaid-eligible children mental health and substance abuse services which exceed, in extent or intensity/restrictiveness, the Diamond State Health Plan basic benefit of up to 30 hours of outpatient service for children through its single integrated system of behavioral health services.

Affiliation Agreements between the DSCYF and each of the MCOs have been established and guide implementation of the partnership.

DSCYF's Divisions of Family Services and Youth Rehabilitative Services provide rehabilitative services for Medicaid-eligible children for which DSCYF claims fee-for-service reimbursement from the Medicaid Office.

General Overview: This graphic shows the roles of the various players in the *Diamond State Health Plan*.

DELAWARE'S 1115 MEDICAID WAIVER
Basic Overview of the CMH Public/Private Partnership



- Medical services will be provided by contract health plans.
- Health Plans will provide up to 30 units/hours of mental health/AOD outpatient services to children.
- All other child mental health/AOD services for children will be provided by DSCYF CMH Managed Care.

Attachments 1 and 2 illustrate the processes, both pre- and post-waiver, for financing and service delivery of child mental health managed care in Delaware.

Key advantages of the Child Mental Health Public/Private Partnership are that it:

- ◊ promotes incorporation of mental health services into primary pediatric care and discourages institutionalization,
- ◊ promotes building on the state's existing service system for moderate to intensive mental health and substance abuse treatment services, thus
 - avoids costly duplication and fragmentation,
 - provides clinical service management to assure treatment in the least intensive, least restrictive level and assures effective transition as youth move across service levels,
 - assures integration of mental health and substance abuse treatment services for Delaware's Medicaid children,
- ◊ promotes continuity of care,
- ◊ eliminates the Medicaid Office's role as direct payor for child mental health services by designating only the capitated contract health plans and DSCYF as payors.

III. DCMHS GOAL

Provide a system of quality child mental health treatment services with:

- accessibility
- services appropriate to individual clients
- a single service system for Medicaid-eligible and non-Medicaid eligible youth and their families and
- fully integrated mental health and substance abuse services.

DCMHS KEY OBJECTIVES FOR FY 96

Implement the role of public managed care organization (MCO) assigned by the Governor's Medicaid managed care initiative, the *Delaware State Health-Plan*, by:

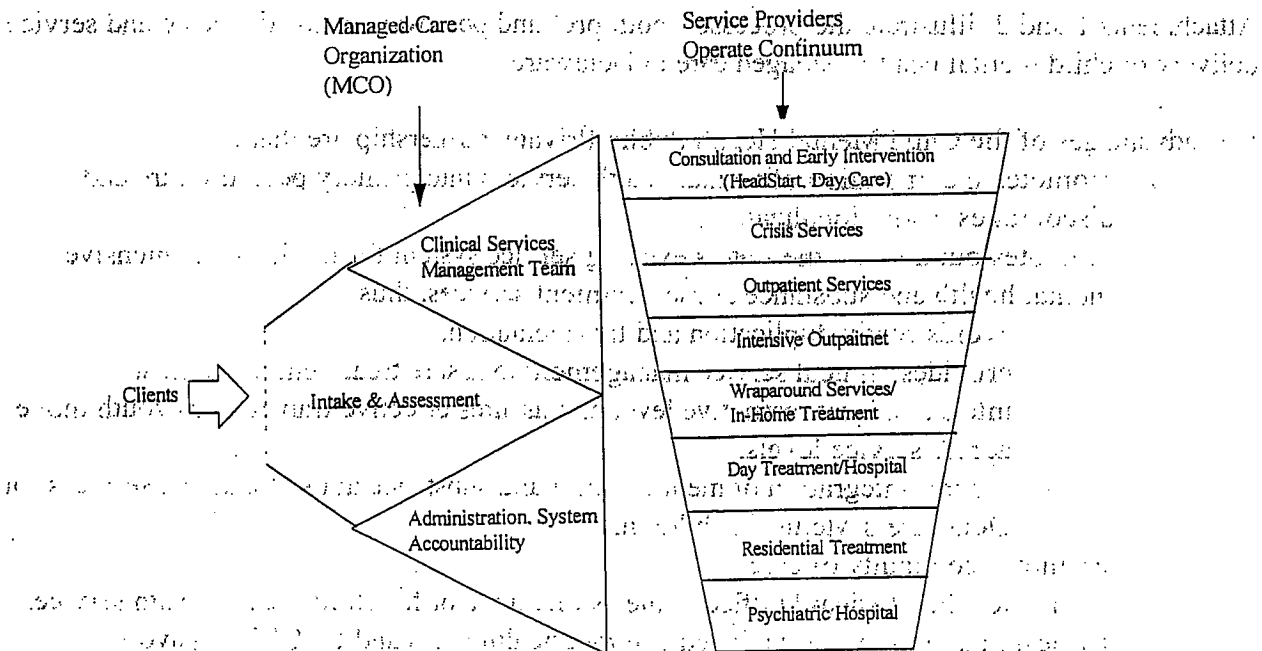
- building gatekeeping,
- enhancing capacity and effectiveness with existing resources,
- building information, accountability, quality improvement.

IV. IMPLEMENTATION

Overview of the DCMHS service system - a public MCO which:

- ◇ serves both Medicaid and non-Medicaid clients/families and
- ◇ fully integrates mental health and substance abuse treatment

The diagram below shows the various key components of the DCMHS child mental health service system. Following the system diagram are brief highlights of each key component.



Relationship of Primary Health Care and Behavioral Health Services

On January 1, 1996, the State of Delaware launched the Diamond State Health Care Plan, a managed-care health program for Medicaid recipients. The plan permits clients to select one of the managed care organizations (MCOs) contracted by the State Medicaid Office. The basic benefit package includes:

- primary and preventive medical care
- inpatient and outpatient hospital and specialty care
- emergency room services
- lab and x-ray services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children
- pharmacy services
- transportation related to medical services

Additionally, an annual benefit of up to 30 hours of outpatient behavioral health services for Medicaid-eligible children is provided by the selected MCO. Outpatient services beyond the 30-hour annual benefit and any more intensive behavioral health service required are provided by DCMHS.

The 1115 waiver under which DCMHS provides services to the Medicaid-eligible population includes about 85% of the DCMHS clients. DCMHS also provides services to clients covered by SCHIP and to those who are uninsured or whose insurance benefits for behavioral health services have been exhausted.

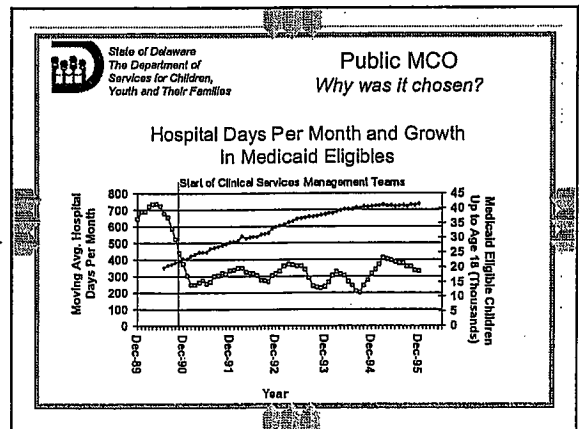
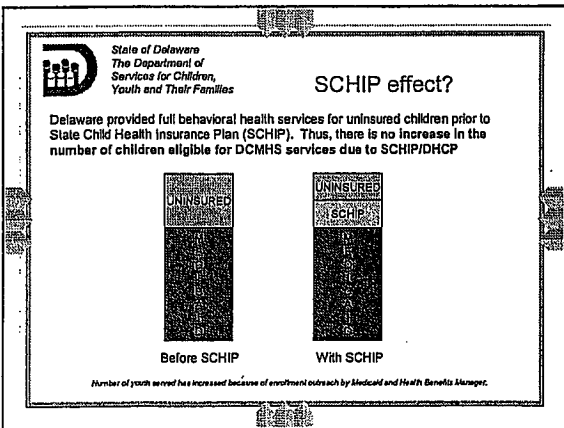
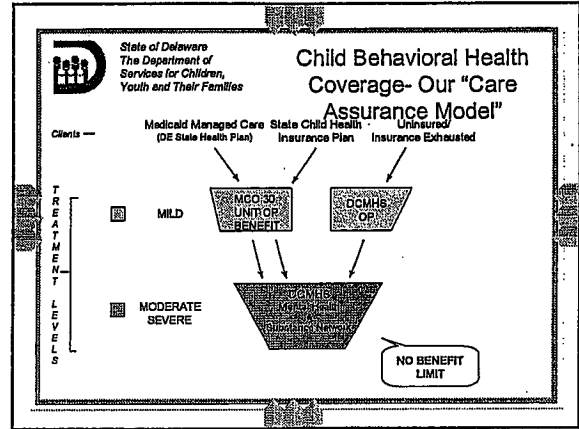
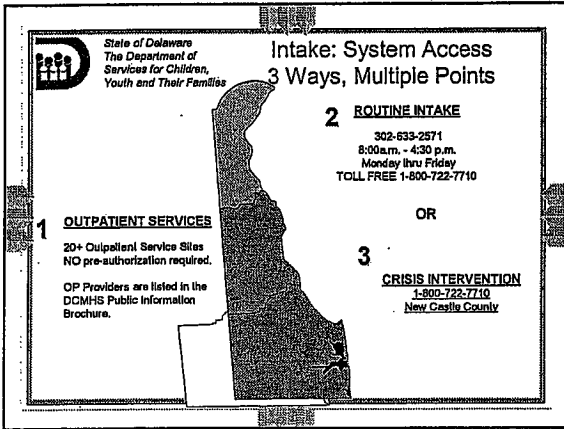
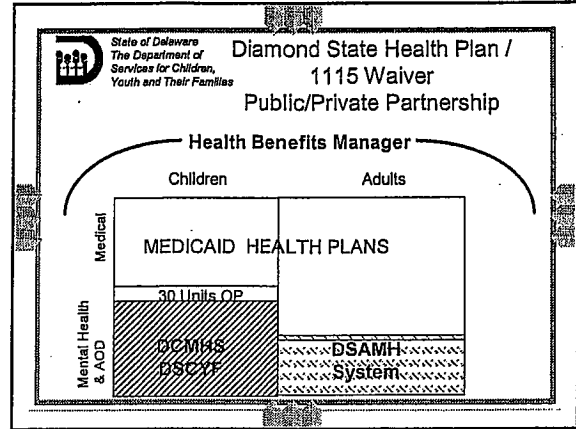
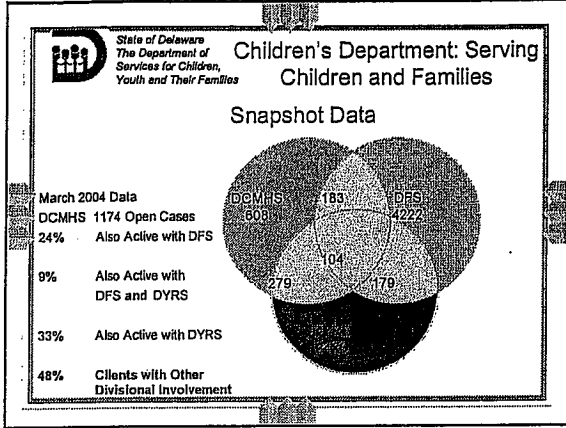
In each case, the CSMT attempts to make contact with the primary health provider and to obtain information about recent health care visits and any health conditions or concerns which the family or health care provider suggest may interact with or influence behavioral health. Performance indicators in this area will be developed further in FY 2003.

The Division utilizes service plans developed with input from the child, the family and other child-serving agencies (i.e. schools, protective services, youth corrections, etc.) to determine the clinically appropriate treatment needed in the least restrictive setting as the guiding principle to dictate the appropriate amount of time a child may receive services. The DCMHS Managed Care/Case Management system and the continuum of behavioral healthcare services DCMHS provides will be described in more detail throughout the balance of this document.

Integration of Mental Health and Substance Abuse Services

In FY 2001, DCMHS expanded its concerns about the integration of mental health and substance abuse services. Research in the field of substance abuse services and DCMHS survey data suggest a high rate of co-occurring mental health and substance abuse issues in the youth population. DCMHS data suggested that up to 52% of youth in mental health treatment exhibited behaviors and had risk factors suggesting the existence of substance abuse problems but only 21% were receiving focused treatment for substance abuse.

EXCERPTS: DCMHS
POWERPOINT 6-9-2004





HealthSouth gets preliminary approval for hospital in Middletown, Delaware



By Russell Hubbard -- The Birmingham News

on October 08, 2011 at 8:00 AM

HealthSouth Corp. has received permission from a Delaware city to build a new hospital, but the proposed project is still a long way from fruition, much less a ground-breaking ceremony.

This week, the Middletown city council approved preliminary construction plans for the \$18.5 million, 34-bed hospital for the rehabilitation of the seriously ill and injured.

But before any construction happens, Birmingham-based HealthSouth must secure final approval from the Delaware Health Resources Board, which earlier denied the proposal. After support from the governor, the board later gave conditional consent to the plan.

"Many factors will affect when we actually break ground," said HealthSouth spokeswoman Helen Todd. "The Middletown council meeting on Oct. 3 was another step in obtaining local approvals needed to get to the point of being able to do so."

Complicating the matter further is that competitor has filed a request for reconsideration of the state agency's decision. A hearing on the matter is scheduled for November. Broadmeadow Healthcare, based in Middletown, is the company that protested the conditional approval of the HealthSouth hospital.

In June, the plan had been rejected by the board, which at the time said similar or identical physical rehabilitation services were available from other hospitals in the same area.

Then Delaware Gov. Jack Markell, a supporter of the hospital's new payroll and construction spending, got involved. He wrote a guest column in Delaware's News Journal newspaper criticizing the board as foes of competition and against economic development.

Seven members promptly resigned, seven new ones were appointed, and the hospital gained conditional approval at an August hearing.

HealthSouth is the nation's largest operator of rehabilitation hospitals, with 97 in 26 states, generating about \$2 billion in annual revenue. The company employs about 400 people at corporate headquarters on U.S. 280.

Join the conversation by clicking to comment or email Hubbard at rhubbard@bhamnews.com.

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STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
MARGARET M. O'NEILL BUILDING
410 FEDERAL STREET, SUITE 1
DOVER, DE 19901

VOICE: (302) 739-3620
TTY/TDD: (302) 739-3699
FAX: (302) 739-6704

March 17, 2011

Mr. Francis Osei-Afriyie, MA, MBA
Delaware Health Resources Board
Jesse Cooper Building
417 Federal Street
Dover, DE 19901

Dear Mr. Osei-Afriyie:

I write on behalf of the State Council for Persons with Disabilities (SCPD) to strongly endorse HealthSouth's application to construct the *HealthSouth Rehabilitation Hospital of Delmarva* in Middletown, DE which will serve persons with disabilities, including persons with traumatic brain injuries (TBIs) and stroke. SCPD is charged in 29 Del.C. Section 8210 with the responsibility of proposing and promoting laws, regulations, programs and policies to improve the well-being of persons with disabilities. In addition, SCPD promotes coordination among programs which impact people with disabilities. Council's membership includes state agencies, persons with disabilities, family members, advocacy organizations and providers.

SCPD supports such an initiative based on the following rationale:

- According to the attached Delaware Health Statistics Center report, TBIs are the type of injury most likely to cause death or permanent disability. Nationwide, approximately 1.4 million TBIs occur each year, resulting in 235,000 hospitalizations and 50,000 deaths. Those TBIs requiring hospitalization are generally more severe and carry higher risks of serious and long-term complications. To assess the impact of TBIs in Delaware, inpatient hospital discharge data from the state's acute-care hospitals were analyzed. From 2003 to 2007, there were 4,847 TBI-related hospital stays of Delaware residents, resulting in a five-year age-adjusted rate of 113 discharges per 100,000 population and a total hospital bill of \$120.9 million. Nearly all of these patients were admitted through the emergency department (ED), and they spent an average of 7 days in the hospital, for a median bill of \$11,252 per stay.
- Acute and long-term services for persons with TBIs are extremely lacking in Delaware as there is truly only one facility in the entire state that has the capability to manage the care of individuals post-injury. There are no such facilities in the primary

area of the proposed HealthSouth facility and most families must send their loved-ones out of state to obtain appropriate care for those who have sustained a TBI.

- The HealthSouth proposal will have a state of the art facility with access to rehabilitation physicians (including neuropsychologists), rehabilitation nurses, physical therapists, occupational therapists, speech-language therapists; case managers and post-discharge services.
- HealthSouth is eager to collaborate with community-based advocacy organizations such as the SCPD Brain Injury Committee and the Brain Injury Association of Delaware.
- HealthSouth's initial plan is to obtain joint commission accreditations with specialty certification in stroke and brain injury. It is willing to seek CARF accreditation consistent with some of its hospitals (e.g. Salisbury MD) if this is important to the community.

HealthSouth's current position regarding outpatient services is that it wants to collaborate with the existing network providers, but understands it may need to do a further assessment of outpatient services and develop some specific programs to meet the needs. SCPD respects HealthSouth's perspective, but does have a concern about initiating the inpatient unit without outpatient therapy being offered at the same facility. Outpatient therapy, specifically regarding cognitive deficits in the TBI population, is a vital part of any inpatient discharge plan and represents the real continuum of care. Council's concern is that such capacity does not exist within the current service providers in that area, and indeed, there is a shortage statewide in this context.

However, SCPD does support the aforementioned application and is looking forward to collaborating with HealthSouth to improve the lives of individuals with brain injuries and their families. A successful application will result in a facility which will allow people with TBIs and their families to have more flexibility and choice about their health care and access to supports and services; reduce the need to send people out of state for care; and increase capacity for such critically needed services in Delaware.

Sincerely,



Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

Scpd/support letters/healthsouth 3-11

Cc: Kelly Shaughnessy, Division of Public Health
Bernard Ableman, Chair, DE Health Resources Board

DHSC Statsheet

Delaware Health Statistics Center

October 23, 2009

Division of Public Health
Department of Health
and Social Services

Traumatic Brain Injury Hospitalizations in Delaware

According to the CDC, TBIs are the type of injury most likely to cause death or permanent disability. Approximately 1.4 million TBIs occur each year, resulting in 235,000 hospitalizations and 50,000 deaths¹. Those TBIs requiring hospitalization are generally more severe and carry higher risks of serious and long-term complications.

A traumatic brain injury (TBI) is defined as a blow or jolt to the head, or a penetrating head injury that disrupts the normal functioning of the brain.

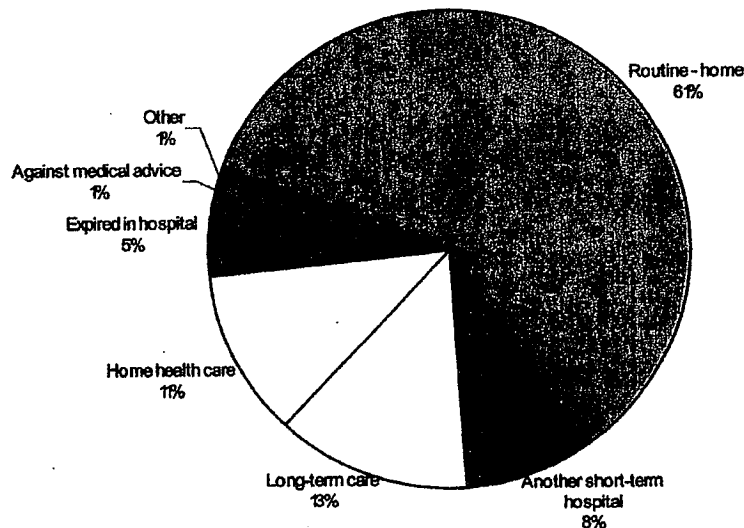
To assess the impact of TBIs in Delaware, inpatient hospital discharge data from the state's acute-care hospitals were analyzed. From 2003 to 2007, there were 4,847 TBI-related hospital stays of Delaware residents, resulting in a five-year age-adjusted rate of 113 discharges per 100,000 population and a total hospital bill of \$120.9 million. Nearly all of these patients were admitted through the emergency department (ED), and they spent an average of 7 days in the hospital, for a median bill of \$11,252 per stay.

The majority of patients hospitalized for a TBI were discharged home, 11 percent were discharged under the care of a home health services organization, 8 percent were sent to another hospital, 13 percent went to a long-term care or similar facility, and 5 percent of patients admitted for a TBI died in the hospital, versus 2.4 percent of all non-TBI patients.

The vast majority of TBI hospitalizations were the result of unintentional injuries.

Falls were the leading cause of TBI-related hospital stays.

Figure 1. TBI Patient Disposition Status, Delaware Hospitals, 2003-2007



Source: Delaware Health Statistics Center

01/10/02 11:15

Patient Characteristics in 2003-2007

New Castle County residents had the highest TBI discharge rate at 125.8 per 100,000 population, followed by Kent and Sussex counties, at 106.4 and 87.1 discharges per 100,000.

Over half of all patients hospitalized for a TBI-related injury were males.

The race distribution of TBI patients was similar to that of the general population; white patients accounted for 73 percent of all TBI hospitalizations, while black patients made up 18 percent of the discharges.

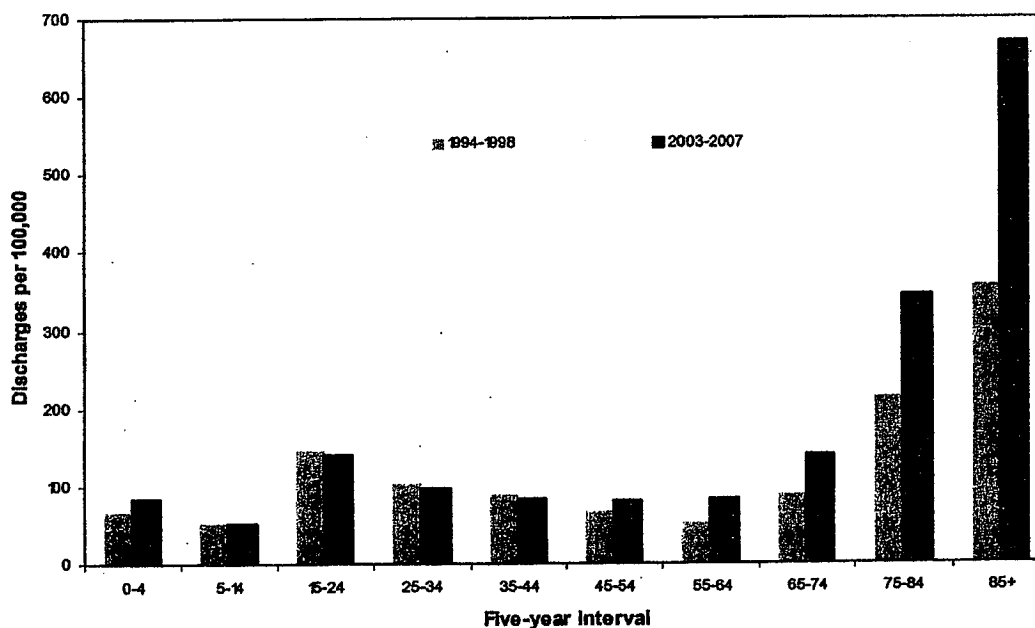
As would be expected of an injury diagnosis, nearly all (94 percent) TBI associated hospitalizations were admitted from the emergency department.

Eleven percent of all hospital stays were children 0-14; teens and young adults ages 15-24 accounted for 17 percent of all stays, while older adults 65 and over accounted for 33 percent of all stays.

The highest TBI hospitalization rates occurred among adults in the 75-84 and 85 and older age groups, at 344 and 669 discharges per 100,000 population

From 1994-1998 to 2003-2007 in Delaware, TBI hospitalization rates increased for patients 0-4 and those 45 and older. The largest rate increases occurred in the 75-84 and 85+ age groups.

Figure 2. Five-year TBI Hospital Discharge Rates of Delaware Residents by Age Group Delaware Hospitals, 1994-1998 and 2003-2007



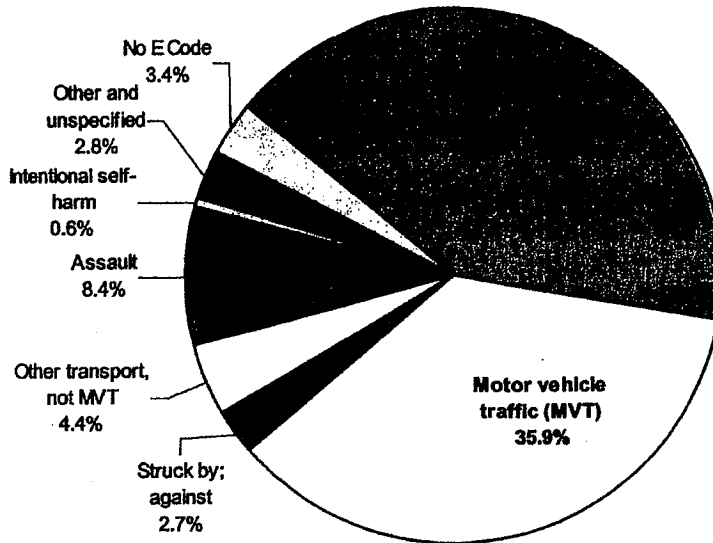
Notes:

Each hospital discharge record has one primary and up to eight secondary diagnoses. TBI-related discharges were identified if any one of the 9 diagnosis fields contained the set of ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) codes for TBI, as established by the Center for Disease Control's National Center for Injury Prevention and Control².

Source: Delaware Health Statistics Center

Figure 3. Percent of TBI-Related Hospitalizations by External Cause Delaware, 2003-2007

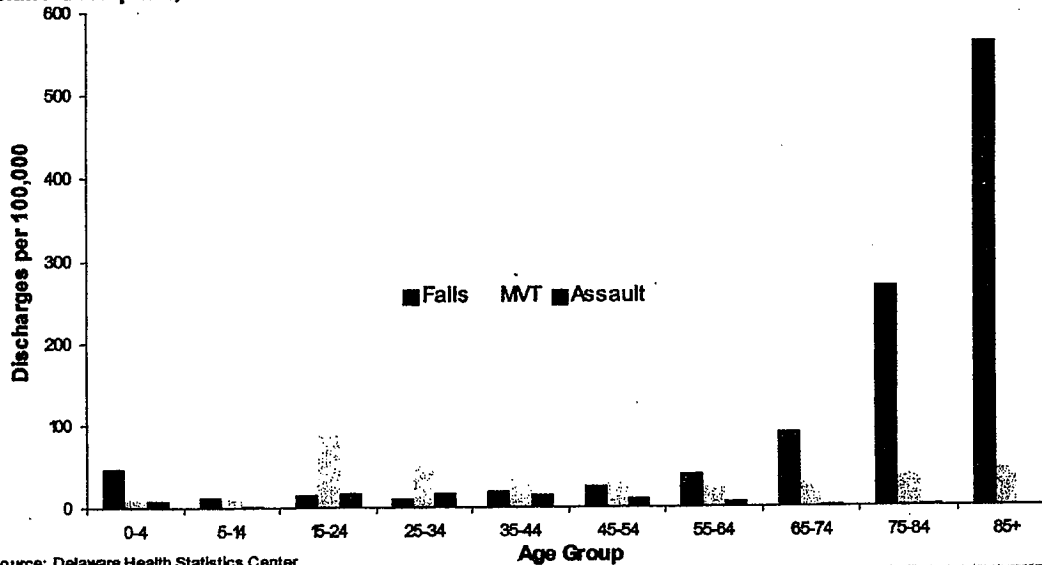
Falls, motor vehicle traffic crashes, and assault were the leading causes of TBIs in 2003-2007. Together, these three external causes comprised 86 percent of all TBI-related hospital stays. Other transport accidents, which include pedal cyclist and pedestrian injuries, accounted for 4 percent. Unintentional struck by/against injuries, which result from being struck accidentally by a falling object, striking against, or being struck accidentally by an object or person, were responsible for 3 percent of all TBIs.



Source: Delaware Health Statistics Center

The rate of fall-related TBIs was highest among adults 65 and older; rates doubled with each increase in age group, beginning with patients 55-64. The 15-24 age group had the highest rates of motor vehicle traffic-related TBIs, while those age groups between 15 and 34 had the highest rates of assault-related TBIs.

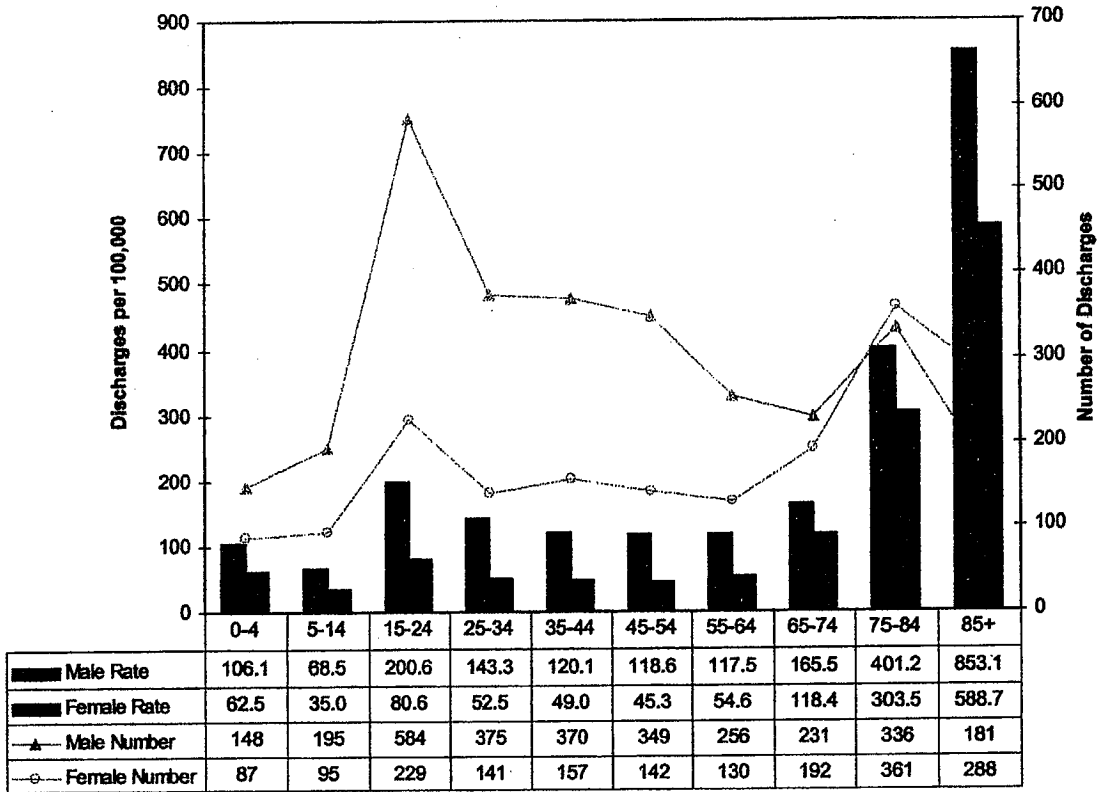
Figure 4. Five-year TBI-Related Hospitalization Rates by External Cause and Age Group Delaware Hospitals, 2003-2007



Source: Delaware Health Statistics Center

Males accounted for 62 percent of TBI associated discharges. TBI hospitalization rates for males were nearly twice that of females; the largest differences were in the 25-34 and 45-54 age groups where the male to female ratios were 2.7 and 2.6.

Figure 5. Five-year TBI Hospital Discharge Frequencies and Rates of Delaware Residents by Age Group and Gender, Delaware Hospitals, 2003-2007



Source: Delaware Health Statistics Center

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DELAWARE HEALTH AND SOCIAL SERVICES

Division of Public Health

Bill would provide shortcut for rehab hospital to open in Delaware

Middletown facility called unnecessary

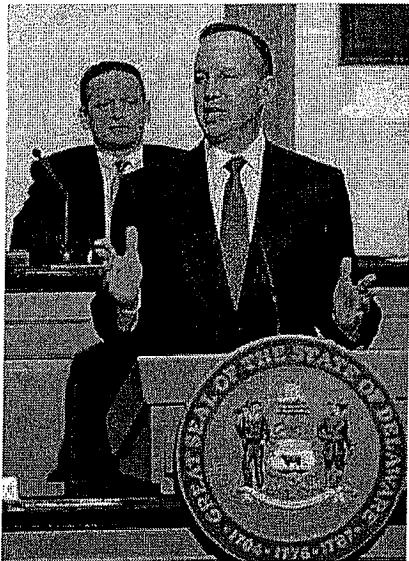
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Gov. Jack Markell

Written by
Jonathan Starkey
The News Journal

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Gov. Jack Markell is backing legislation that would allow Alabama-based HealthSouth Corp. to build a rehabilitation hospital in Middletown without a state review, despite a legal challenge and claims that the governor exerted improper political influence to move the deal forward.

The bill, sponsored by Rep. Quinn Johnson, D-Middletown, exempts freestanding rehabilitation hospitals from a certification review before the Delaware Health Resources Board.

Two years ago, after HealthSouth's application, members of the board resigned in protest, including the board chair, who accused Markell of improperly meddling by replacing board members during the review process. Broadmeadow Investment LLC, the

operator of a Middletown nursing home that would compete with HealthSouth's facility, is now suing the resources board for later approving the deal.

Markell has said the hospital should be built, claiming it would create 80 permanent jobs and encourage health care competition.

Bernard Ableman, who served as chair of the health resources board before resigning in 2011 and accusing Markell of putting pressure on the board, called it "inappropriate" for lawmakers to circumvent the process and approve the deal through legislation.

Board members looking into HealthSouth's application in 2011 found the proposal would likely lead to "overbuilding" and unnecessary health care billing.

"Assuming that it's going to exempt certain facilities from the review process, then the question is why do we have the process at all?" said Ableman, a lawyer who served on the health board for 16 years.

The Health Resources Board is tasked with assessing the quality, availability and cost of health care in the state before certifying new health facilities.

In HealthSouth's case, the company wants to build a freestanding hospital to treat patients with brain and spinal cord injuries, as well as patients recovering from strokes. HealthSouth and its advocates, including Markell, have argued that many Delawareans have to travel out of state for such treatment.

(Page 2 of 3)

The proposed legislation would exempt only freestanding rehabilitation hospitals from review by the board. It is a targeted effort to approve HealthSouth's hospital, and could essentially end the legal fight with Broadmeadow Investment. The case is back in Superior Court after the Delaware Supreme Court ruled Broadmeadow has the necessary standing to bring the case.

Lawyers for Broadmeadow argue, in part, that new Health Resources Board members appointed during the review process did not hear all of the briefings necessary to approve the deal. Several members who opposed the deal resigned.

"There is obviously a divergence of opinion as to whether there should be a health resources board that looks at overall need and tries to make sure facilities are not built which are unnecessary," said Richard Beck, a lawyer at Morris James who is representing Broadmeadow.

More than 30 states have so-called "certificate of need" programs that study the necessity and potential impact of new health care facilities before allowing construction.

Markell, Johnson and others contend that a new hospital would encourage health care competition, dismissing any claims of higher costs. "I've never seen in my business environment an experience where competition has ever increased the price of something," Johnson said.

Advocates of certificate-of-need programs, including Ableman, say that argument represents a misunderstanding of health care. They say health care companies do not operate in a free marketplace, where consumers shop around for the lowest price. Too much health care capacity – too many rehab beds, in this case – can lead to overutilization and higher costs, Abeleman said.

"Health care is out of control in this country. This is the one process that can exercise control over the cost of health care," he said. "To dilute that process, I think, is a mistake."

Setting the HealthSouth review apart, however, were claims of political meddling. HealthSouth hired a powerful Dover lobbyist – Robert Byrd – to steer the deal toward approval.

Page ¶ Previous 1 2 3 Next ¶

(Page 3 of 3)

And Markell appointed six new board members, filling empty positions and replacing two members who opposed the HealthSouth proposal. Their terms had previously expired, but some members were nonetheless taken aback by the move, saying Markell was stacking the deck to approve the deal.

Samuel Lathem, president of the Delaware AFL-CIO, asked another board member, J. Kenneth Saunders, to resign.

Ableman claimed that Markell played a role in that resignation. Lathem said he asked Saunders to resign because he voted against a project that labor interests supported, not because of Markell. Saunders was on the board as a labor representative, Lathem said, "and he didn't support labor on that issue."

Nevertheless, decrying improper political influence, Ableman and others opposed to the deal resigned their board posts. That led to the approval of HealthSouth's plans and Broadmeadow's subsequent legal challenge, which argues that the new board members were unable to properly judge HealthSouth's proposal.

Johnson's legislation, which would pave the way for the hospital's construction, has been assigned to the House Health and Human Development Committee, but does not yet have a hearing date. Middletown officials have approved HealthSouth's plans.

Biden proposes gun-control ban for new group

Bill aims to bar access to larger mentally ill list

By Jonathan Starkey
The News Journal

Attorney General Beau Biden is proposing legislation that allows a judge to ban someone from owning a gun if a



Beau Biden

mental health worker tells police the person is a danger. The bill is the latest in a series of gun-control proposals in Delaware, filed less than a week after the General Assembly passed a measure requiring buyers in private gun sales to undergo a background check.

The Biden-backed legislation would require mental health providers to call police if they suspect a patient presents a danger to himself or others. Police would be required to investigate and make a report to the state Department of Justice in determining whether the person should be banned from possessing a firearm.

Prosecutors could ask a judge to ban the mentally ill individual from owning weapons and seize guns that person already owns. If the mentally ill person is a juvenile living with parents, anyone in the household could be forced to turn over guns.

Mental health professionals who fail to follow the regulations could

have their licenses revoked. Physicians, nurses and social workers, including those working in schools, would fall under Biden's bill.

Under current Delaware law, only individuals involuntarily committed to a mental institution are banned from owning guns. The proposed legislation, which has bipartisan support, would add to the list individuals found not guilty of a crime by reason of insanity or incompetent to stand trial because of a mental illness.

The bill also could affect suicides by keeping guns away from individuals who are mentally unstable, Biden said. "We know this is an area where we need to take action," he said Monday.

Dr. Neil Kaye, a Hockessin psychiatrist, spoke in favor of the bill, saying it affords individuals "due process" before potentially banning their possession of a firearm.

James Lafferty, executive director of the Mental Health Association in Delaware, added his support.

Rep. Mike Barbieri, a Newark Democrat and licensed social worker, and Rep. Deborah Hudson, R-Fairthorne, are backing the legislation. Sen. Dave Sokola, D-Newark, will shepherd the bill through the Senate.

"It's time to realize that people with mental health [issues] commit crimes, small crimes but also these mass murders," Hudson said. "It's a sensitive issue. There are issues of privacy, but an appropriate bill could go a long way to making us safer."

Contact Jonathan Starkey at 983-6756, on Twitter @jwstarkey or at

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OPINION

Howard L. G.
President and
David F. Ledl
Executive Edit
John Sween
Editorial Page

The NewsJournal ...

OUR V

Gun bill clarifies rules in mental health law

Protecting people against gun violence sometimes is a matter of protecting people against themselves.

In a perfect world, people would not pose such a threat. Even in an imperfect but better attuned world, that protection would be readily available.

Unfortunately, cries for help sometimes go unheard in our noisy, imperfect world and individuals can put themselves and others in danger.

Recent history testifies to what can go wrong. The shootings at Columbine and Aurora, Colo., and most recently in Newtown, Conn., show what can happen when mentally disturbed people have access to guns.

No perfect solution exists, but on Monday, Delaware Attorney General Beau Biden, Health and Social Services Secretary Rita Landgraf and

several legislators highlighted a proposal that could help prevent such tragedies from happening here. The bill would expand the mental health provision in state gun-restriction laws by keeping guns from people determined by a court to be "a danger to themselves or others."

The bill also would strengthen mental health professionals' responsibility for reporting people they believe to be dangerous.

The officials worked with a variety of mental health advocates to protect the civil rights of all people and to make sure no one can deprive another person of their Second Amendment freedoms. This is an important caveat in any such proposal.

No bill can fix all of our problems. This one needs to be vetted thoroughly. But it has the potential of providing real help.



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Monday, April 22, 2013 - 4:03pm | Updated Monday, April 22, 2013 - 4:31pm

VIDEO: New bill seeks to tackle mental health component of gun violence

By: Amy Cherry

[Click here to watch the video of this story](#)



Attorney General Beau Biden talks about the bipartisan legislation he's backing.

New legislation, backed by Attorney General Beau Biden, seeks to strengthen the state's mental health prohibition on gun ownership.

WDEL's Amy Cherry reports.

[Click here to listen](#)

People determined by the court to be a danger to themselves or others, those found

guilty but mentally ill, or those incompetent to stand trial would be barred from possessing a gun.

Attorney General Beau Biden says the hope is this will prevent mass murders like Sandy Hook and the tragedy in Aurora Colorado, from happening here.

"A month before that massacre, (James) Holmes told his psychiatrist that he wanted to kill people. His psychiatrist alerted University of Colorado police, and his campus ID was deactivated," says Biden.

[Click here to listen](#)

Perhaps the most controversial provision: parents of mentally ill teens could also have guns taken away.

"It would depend upon a judge's order about the child's access to that weapon and whether them living in a home for which they have access is in violation of the law," Biden says.

[Click here to listen](#)

But to be clear, Biden says, "Just seeking mental health treatment does not prohibit you from owning or possessing a gun.

[Click here to listen](#)

If these individuals, who are prohibited from possessing a gun, demonstrate to a court that they're no longer a danger to themselves and others, they can get their guns back under the legislation.

Delaware Department of Health and Social Services Secretary Rita Landgraf says this measure could've saved the lives of the youth who killed themselves in Kent and Sussex Counties last year.

"Many of those individuals took their life by use of firearm, and that is pretty significant when you think about the loss of life," says Landgraf.

[Click here to listen](#)

The measure has bipartisan support with Rep. Mike Barbieri (D-Newark), Sen. David

Sokola (D-Newark) and Rep. Debbie Hudson (R-Fairthorne) being its prime sponsor. The medical community is also backing the measure.

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Delaware attorney general announces new gun-control legislation

By Associated Press, April 22, 2013

WILMINGTON, Del. — Delaware Attorney General Beau Biden proposed legislation Monday aimed at keeping people considered a danger to themselves or others from getting their hands on guns.

The bill, which Biden called a response to mass shootings in the U.S. by people with known mental health problems, expands the ability of authorities in Delaware to prohibit people with mental health issues from having access to guns.

Under current law, a person who has been committed to a hospital or mental health institution for a mental disorder can be prohibited from possessing a gun.

"The mental health category is too narrow. It needs to be expanded," Biden said.

The legislation proposed Monday would expand the mental health prohibition against possessing guns to include individuals deemed to be a danger to themselves or others. Criminal defendants who have been found guilty but mentally ill, not guilty by reason of insanity, or incompetent to stand trial also would be prohibited from having guns.

The bill requires mental health providers, including licensed school counselors, to call police if they believe a person poses a danger to himself or others. Police would investigate and would refer the case to the state Department of Justice if they believe the person shouldn't have access to a gun.

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The DOJ could then ask a judge to prohibit the person from owning or possessing a gun. The judge also could order the seizure of any guns that the person owns. In the case of a troubled child, authorities could seize any guns owned by a parent or guardian with whom the child is living.

Biden and other proponents said the legislation balances the rights of mental health patients with public safety.

"Just seeking mental health treatment does not prohibit you from owning or possessing a gun under current law or this legislation," said Biden, adding that the bill was a "practical, commonsense approach" to reducing gun violence, including suicides.

Rep. Michael Barbieri, a Newark Democrat and licensed social worker who is co-sponsoring the legislation, said that if the bill prevents just one person from killing himself or herself, or another person, he would feel that he's done his job.

Republican House Minority Whip Deborah Hudson, R-Wilmington, who supports the bill, said the mental health aspect of gun violence has been suppressed "long enough."

"It's the person who commits the crime, not the weapon," she said.

The legislation is tied to a broader package of gun-control measures proposed by Biden and Democratic Gov. Jack Markell in the wake of the December school shooting in Connecticut.

Lawmakers last week gave final approval to a bill expanding criminal background checks on gun purchases in Delaware to include most transactions between private sellers and buyers.

Markell also is pushing for bans on the sale of high-capacity magazines and military-style assault-type weapons and new restrictions on guns near schools.

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Specialty-Tier Prescription Drugs

Report to the General Assembly

Prepared by the Delaware Health Care Commission

March 15, 2012

Introduction

On September 14, 2011, Governor Jack Markell signed Senate Bill 137 ("SB 137") directing the Delaware Health Care Commission to "conduct a study for specialty-tier prescription drugs to determine the impact on access and patient care". SB 137 required the Commission to report its findings to the General Assembly by March 15, 2012.

The Commission convened public meetings in December 2011 and February 2012 for the purpose of gathering information related to the use of specialty-tier drug pricing. In addition to information gathered during public meetings, the Commission gathered information related to prescription drug costs approaches taken at the state and federal level to address this national issue, and actual and potential impact on patients, health care providers, employers and other stakeholders.

Background

In Delaware and in the nation, health care costs are rising. Health care spending in the U.S. has increased by an average of 6.8% annually over the last decade, reaching \$2.6 trillion in 2010, at 17.9% of the nation's Gross Domestic Product (GDP), and projected to reach \$2.7 trillion in 2011. The State of Delaware now spends \$1.2 billion in state and federal taxpayer dollars on health care each year. Across all payers, health care expenditures for Delawareans reached \$7.5 billion in 2009. In 2009 and 2010, health care expenditures grew at a rate of 3.8% and 3.9% respectively, the two slowest rates in the 51 year history of the National Health Expenditure Accounts. Even an annual increase of 3.9% per year, however, would translate into total health care expenditures in Delaware of \$8.5 billion in 2012.

The cost of health care is much more than a single number. The cost of health care nationally and in Delaware is the complex result of actions, reactions and sometimes inaction in a system designed to pay for services rather than improved outcomes and better health for Delawareans. Our health care system is at a critical juncture with escalating costs, disappointing outcomes and increasing safety concerns, as well as demographic, population health and economic shifts that place an ever-increasing burden on the system itself and the taxpayers, businesses and public institutions that support it.

While health care cost drivers are very complex, we are making significant progress in examining this area. For example, we know that the cost of preventable lifestyle-related illness in Delaware is more than \$900 million each year and we know that detecting many cancers at an earlier stage improves survival and significantly reduces cost of care. We also know that Delaware's investment in the health care technology infrastructure provided by the Delaware Health Information Network ("DHIN") is already reducing the incidence of high cost tests and will provide a critical foundation for new health care delivery models such as patient centered medical homes and accountable care organizations. These models can support higher quality, better coordinated care, improved outcomes and reduced costs.

One cost which several states have recently begun to address is that of prescription drugs. The cost of prescription medications is a critical driver of overall health care costs with pharmaceuticals accounting for 10.0% of the total U.S. health care expenditures. As with the overall cost of health care, the cost of prescription drugs is complex and related to the larger health care system. For example, there are methods to reduce the cost of medications such as rebates paid by drug companies to health insurers. These rebates are not typically included in estimates of prescription drug costs. Nationally, Medicaid spending for brand-name drugs actually increased at a lower rate than the inflation rate from 2005-2009 when rebates were included in cost calculations.

When affordable, available and used appropriately, prescription drugs, such as those to manage diabetes, have the potential to improve quality and length of life and productivity as well as to reduce use of other components of the health care system. Recently, actions have been taken in several states to address the affordability of particularly

expensive prescription drugs known as “specialty” drugs. The impact of those actions on cost of and access to specific medications is the subject of this report.

What are specialty-tier medications?

Specialty-tier medications are high cost drugs for which patients may be required by their insurance plan to pay a proportion of the total charge for the drug, referred to as co-insurance, rather than fixed amount, referred to as a co-payment. Insurance plans can include this requirement in the medical and/or pharmacy benefit. These medications generally target very specific medical conditions and may require special handling or application. Each insurance plan develops its own list of specialty-tier drugs. Changes to that list can occur at any point in the plan year. This means that rather than pay a \$10 co-pay to fill a prescription, a patient is instead required to pay a percent, such as 25%, of the total cost of the prescription. It should be noted that co-insurance is typically calculated based on the amount drug companies charge. Because health plans routinely negotiate with drug companies to receive rebates for individual drugs, the actual cost the insurer pays for the drug may be significantly lower than the amount charged initially. As a result, patients may pay a significantly higher percentage of the actual cost of a drug.

Why are specialty tiers used?

The primary purpose of specialty tiers is to share the cost of particularly expensive drugs between patients and health insurance plans. Other approaches to controlling and shifting cost include step therapy, which require patients to first try similar but less expensive drugs, and prior authorization, which requires health care providers to justify the medical necessity of these more expensive drugs.

Is the use of specialty tiers an increasing trend?

The increasing trend is the ever-increasing pipeline of the prescription drugs and biologic agents that have a strong potential to fall into a specialty-tier category due to their high cost. The number of drugs being placed on the Medicare Part D specialty tier has increased from 100 in 2006 to 160 in 2008. Specialty-tier drugs were once reserved for patients with rare diseases, but now are often used to treat chronic conditions such as multiple sclerosis, rheumatoid arthritis, and certain cancers. Based on the discussions at the hearings held, it is a fair assumption that we will see an ever increasing array of high cost prescription treatment options, accompanied by all the benefits as well as the cost considerations at issue in this report.

What is the impact when specialty tiers are used?

When specialty-tier pricing is used, consumers absorb a larger proportion of the cost of prescription drugs in the specialty category. The impact of this increase varies depending on the amount of the increase, whether and to what extent use of the drugs eliminates other health care costs (out of pocket costs for the patient, use of other components of the health care system, etc.), and the patient’s financial status. Affordability is a critical determinant of access to health care. When medical care, including prescription medications, is not affordable, patients cannot and do not use it. Cost-related medication non-adherence is well documented in patients with a variety of health conditions including end-stage renal disease, cancer, depression, arthritis and other illnesses. Consequences of lack of adherence to medication regimens are also well documented and vary depending on the health condition. In general, consequences include poorly managed disease and increased complications. For some conditions including multiple sclerosis, these medications most often stop or significantly delay the progression of the disease. For example, they are absolutely essential for salvaging any quality of life for patients with multiple sclerosis. If they become inaccessible due to cost issues, research indicates that patients’ ability to function in all areas of life is severely impacted. In certain health conditions (e.g. hemophilia, HIV/AIDS, and cancer), inability to access medications can be life threatening.

A very real impact of specialty tiers is the potential to place certain high-cost prescription drugs out of the reach of some or even much of the population. One example provided was for a hemophilia drug at the cost of \$30,000 per month. With the institution of a co-pay in the 25% range, without a cap, many families would be faced with very significant financial hardship or the simple inability to afford to take the drug. Beyond the individual impact on consumers, potential effects of specialty tiers on the health care system as a whole include increases in Medicaid enrollment as families look to public assistance in the absence of other means of accessing care.

Another consideration is the potential impact on health insurance premiums. Given the potential for significant increase in utilization and prevalence of high cost medications, in the absence of increased cost shifting via mechanisms such as co-insurance, or reductions in other health care spending, health claims may increase and result in higher health insurance premiums for consumers. Under the Medical Loss Ratio requirements in the Affordable Care Act, insurance companies in the individual and small group markets must spend at least 80% of the premium dollars they collect on medical care and quality improvement activities. Insurance companies in the large group market must spend at least 85% of premium dollars in the same areas. If there is a net increase in expenses, there is a risk that premiums will be affected as well.

Specific positive and negative consequences of the use of specialty-tier pricing vary by stakeholder group and include:

Specialty-Tier Pricing for Prescription Drugs		
Stakeholder Group	Benefits	Concerns
Health care consumer	May help to control the cost of health care premiums	Purchasers of health insurance (especially those purchasing individual coverage) disproportionately affected by higher premiums and co-insurance
Patient		Restricts access to medications for those unable to pay, disproportionately impacts the sickest patients and leads to worsening illnesses and non-compliance
		Co-insurance is based on the retail cost of drugs, not on actual cost to insurers after rebates. Patients may pay a significantly larger portion of the actual cost of the drug than the co-insurance requirement.
Health care provider	Helps providers include the issue of cost of care in treatment planning discussions with patients	Cost of care discussion competes with messages patients receive in other venues (media, friends, relatives, etc.) about treatment choices
		Complicates treatment planning and limits provider's use of medical judgment to develop an individualized treatment plan

Employer	Medication costs are shared with employees	Lost productivity, higher health care and disability insurance costs as employees' health conditions go unmanaged
Pharmaceutical manufacturer		Lower utilization of prescription drugs decreases revenue
		Inconsistent use of medications complicates analysis of efficacy
Health insurer	Decreased share of costs results in increased revenue.	Unhealthy insured population can result in higher costs (NOTE: MLR requirements set by ACA will negate any impact on insurers)
Public policy	Help health care consumers understand cost of health care Allows for preserving and prioritizing resources to help provide specialty tier drugs for those who are most in need of them, where clinically appropriate	Contrary to principle of equitable sharing of risk and cost
		May disproportionately affect small states
		Disproportionately affects people with conditions that are typically treated with specialty products, such as rheumatoid arthritis, cancer, hemophilia, HIV/AIDS, or multiple sclerosis. Often, patients with these conditions have no lower-cost options available to treat their disease and may be least able to afford their prescription drug under a co-insurance model
Public health		Limits access to health care for vulnerable and at-risk populations
		Lack of treatment/management for communicable diseases results in increased transmission and higher infectivity (e.g., HIV/AIDS)

Recommendations

The Delaware Health Care Commission is acutely aware of the need to assure access to medications. Delaware cannot allow a situation in which life-saving medications are out of reach for patients in need simply because the drugs are too expensive. The Commission also recognizes that continued increases in health care costs are unsustainable and supports the use of tools to share and manage those costs, as well as incentives to encourage use of cost-effective, well-coordinated preventive health and disease management services. These efforts are critical to reducing the costs that many agree are preventable, and maintaining the capacity to provide critical access to needed drugs.

In order to assure access to prescription drugs while retaining tiered pricing as a tool to encourage healthy behaviors and the most cost-effective use of health care resources, the Delaware Health Care Commission recommends that use of specialty tiers using co-insurance to control costs should only occur when:

- Therapeutically similar drugs are available in lower cost tiers
- Specific measures to assure affordability are in place
- Processes for designating specialty-tier drugs are uniform and transparent to all stakeholder groups, including providing appropriate notice

Potential options to accomplish these recommendations include:

- Legislation restricting the use of co-insurance payment structures for specialty medications.
- Implementation of tiered pricing combined with caps for limiting out of pocket expenses. The inpatient payment structure may be used as a model.
- Creation, implementation, dissemination and ongoing evaluation of disease-specific uniform treatment guidelines/treatment pathways.
- Implementation of statewide programs to share cost and risk (e.g. use of captives or reinsurance programs to bear the high cost risks).

The Delaware Health Care Commission is available to continue to research and explore potential options and recommendations.

During the process of gathering information and developing recommendations related to specialty-tier pricing, the Commission heard a variety of issues and concerns related to the availability, affordability and quality of prescription drugs in general. These include:

- Special issues related to children including:
 - Health conditions and treatments unique to children.
 - The significantly larger proportion of children covered by public insurance programs as compared to the adult population.
 - Economics of developing and marketing drugs for children.
- Factors influencing prescription drug pricing, and actual costs from research and development through consumer use and demand including use of rebates.

- Drug shortages
- “Orphan” drugs, defined as products that treat rare diseases or conditions and affect a very small number of individuals.

While these issues are not directly related to this report, the Commission recognizes that these factors have a significant “upstream” impact on cost, access and quality of health care.

The Commission wishes to thank the following people for their insight and suggestions which helped to assure a full and meaningful discussion of this complex issue:

Barron, John	- HealthCore
Bishop-Murphy, Melissa	- Pfizer
Blunt-Carter, Maria	- Delaware HIV Consortium
Burkhardt, Kathy	- Johnson & Johnson Health Care Systems
Byrd, Rebecca	- The Byrd Group
Chiquoine, Jeanne	- American Cancer Society
Corbo, Chris	- Christiana Care Health System
Denemark, Cynthia	- DHSS/Division of Medicaid and Medical Assistance
Eldreth, Alex	- National Multiple Sclerosis Society
Fields, MD, JoAnn	- Private Practice Physician
Gomes, Kimberly	- The Byrd Group
Hamilton, Deborah	- Cozen O'Connor
Hamilton, Sebastian	- Christiana Care Health System
Harrington, Kathy	- Corporation Service Company
Heffron, A. Richard	- Delaware State Chamber of Commerce
Heiks, Cheryl	- Cozen O'Connor
Houston, Lois	- Office of Management and Budget/Statewide Benefits
Jennette, Susan	- Delaware Insurance Department
Jones, Tyrone	- AstraZeneca
Kanara-Kempf, Colleen	- AstraZeneca
Kaplan, MD, Paul	- Blue Cross Blue Shield of Delaware
Kirk, William	- Blue Cross Blue Shield of Delaware
Lafferty, James	- Mental Health Association in Delaware
Lakeman, Brenda	- Office of Management and Budget/Statewide Benefits
Mann, Ben	- Arthritis Foundation
McCabe, Maria	- Multiple Sclerosis Society, Delaware Chapter
Meehan, Matthew	- Pfizer
Nemes, Linda	- Delaware Insurance Department
Nicholaou Francino, Terri	- W.L. Gore & Associates, Inc.
Pando, MD, FACP, Jose Antonio	- Private Practice Physician
Posey, Brian	- AARP
Rao, Nitin	- Medical Society of Delaware
Riveros, Bettina	- Office of the Governor, Delaware Health Care Commission
Rogers, Ann	- National Hemophilia Foundation, Delaware Valley Chapter
Roy, Roger	- Burriss Firm representing Medco
Ryan, Mary	- Medco Health Solutions
Schiltz, Christine	- Parkowski, Guerke & Swayze
Sykes, James	- HealthHIV
Trujillo, Geralyn	- AARP
Vannicola, Luke	- National Hemophilia Foundation
Vaughn, Erin	- AstraZeneca
Wallace, Cecil	- Arthritis Foundation Mid Atlantic Region

Delaware Health Care Commission Staff:

Jill Rogers, Executive Director (current)
 Paula Roy, Executive Director (former)
 Marlyn Marvel, Community Relations Officer

Robin Lawrence, Executive Secretary
 Linda G. Johnson, Administrative Specialist III

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Letters:

Burkhardt, Kathy - Johnson & Johnson Health Care Systems
Gileno, Paul – U.S. Pain Foundation
Hamilton, Deborah – Cozen O'Connor
Pando, MD, FACP, Jose Antonio – Private Practice Physician

Rogers, Ann - National Hemophilia Foundation, Delaware Valley Chapter
U.S. Pain Foundation, Autoimmune, Arthritis Foundation, Delaware Nurses Association, HealthHIV, MS Tax
Checkoff, National Hemophilia Foundation
Vannicola, Gail – parent of child with hemophilia
Wallace, Cecil – Arthritis Foundation



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
MARGARET M. O'NEILL BUILDING
410 FEDERAL STREET, SUITE 1
DOVER, DE 19901

VOICE: (302) 739-3620
TTY/TDD: (302) 739-3699
FAX: (302) 739-6704

MEMORANDUM

DATE: June 28, 2012

TO: All Members of the Delaware State Senate
and House of Representatives

FROM: Ms. Daniese McMullin-Powell, *DMP/k.e.* Chairperson
State Council for Persons with Disabilities

RE: S.B. 262 [Dental Coverage]

The State Council for Persons with Disabilities (SCPD) has reviewed S.B. 262 which expands Delaware's Public Assistance Code to provide preventative and urgent dental care to all eligible Medicaid recipients. Payments for preventative or urgent dental care treatments shall be subject to a \$10.00 recipient copay and the total amount of dental care assistance provided to an eligible recipient shall not exceed \$1,000.00 per year, except that an additional \$1,500.00 may be authorized on an emergency basis for urgent dental care treatments through a review process established by the State Dental Director. SCPD endorses the concept of the proposed legislation and has the following observations

Research on dental health suggests that poor oral health is linked to increased risks for chronic health conditions such as heart disease and diabetes. This problem is even more pronounced among individuals with disabilities because of their notoriously limited access to dental care. A survey conducted on the health status of individuals with disabilities in Delaware showed that almost a quarter (24.3%) of adults surveyed did not receive regular dental care. Adults who depend on state health insurance do not have dental care coverage through Medicaid.

While many of us have some anxiety, financial difficulty, or other challenge associated with our access to dental care, individuals with disabilities often face multiple difficulties. Recent studies have shown that one's knowledge of dental care is a major predictor of dental health. Patients with cognitive disabilities are often dependent on others for assistance, whether for transportation, home care activities, decision-making about treatment, and/or payment. Physical disabilities can limit a patient's ability to practice effective dental hygiene and access adequate care in a dental office. While Delaware offers a good Medicaid program to meet the needs of children who qualify, virtually no financial assistance is available for adults with unmet dental needs.

In summary, the lack of state funding for adults with disabilities is a major impediment to dental care, and poor dental health is known to be a factor in a wide range of non-dental medical conditions.

Thank you for your consideration and please contact SCPD if you have any questions regarding our position or observations on the proposed legislation.

cc: Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

sb 262 dental coverage 6-28-12

4-24-13

Bill sets higher teacher standard

Proposal would affect education programs

By Nichole Dobo
The News Journal

Aspiring public school teachers in Delaware will face new academic challenges if legislation proposed Thursday is successful.

The bill is meant to improve the quality of educators in the state's school system. It would set higher standards for being admitted to teacher-education programs within Delaware and introduce tests that graduates must pass to prove they are ready to teach.

The changes would, for the first time, set a minimum grade point average requirement for those who wish to study education at a Delaware college, according to the governor's office. It would also create a new test — similar to the bar exam for lawyers — that teachers must pass to become certified.

Gov. Jack Markell signaled in his State of the State address this year that changes to teacher preparation programs would be among his top priorities. The legislation, Senate Bill 51, is sponsored by Sen. David Sokola and Rep. Darryl Scott.

"This is just one more important step we can take to make sure we are getting the right people into teaching, making sure we are providing the proper support when they're in higher ed and the like," Markell said.

The legislation also would put new



Gov. Jack Markell

See BILL, Page B9

Bill: DSEA supports changes

Continued from Page B1

requirements on the state's teacher-education programs. For instance, it would require them to collect and publicly report data on outcomes of graduates and boost the level of clinical experience for training programs.

Teacher preparation programs are an important part of the state's work to improve the state's schools, said Paul Herdman, CEO and president of the Rodel Foundation of Delaware, a nonprofit that advocates for education reform.

"This is a people business and we know having strong teachers — or not-so-strong teachers — can really change the trajectory of a child's life," Herdman said.

Open-enrollment teaching programs, such as Wilmington University's, could face the most changes if the legislation passes. The bill does provide some flexibility — by allowing up to 10 percent of students admitted to take a state-approved test to demonstrate their academic qualifications.

Wilmington University believes its program is strong because it sets high standards to graduate, said Peter Bailey, vice president of external affairs. The private university has connections with the teachers of the year from 2006-12, he noted.



Frederika Jenner

Bailey declined to say if the university will lobby to remove the minimum grade point average standard from the legislation.

"If they pass the bill as proposed — we are going to support it," he said.

The University of Delaware supports changes proposed in the legislation, said Nancy Brickhouse, the university's interim provost.

"Teachers should be able to hit the ground running, so to speak," she said.

However, there is concern about a proposed requirement to collect and share data that would measure the outcomes of graduates after they are teaching, Brickhouse said. It will cost time and money, and create a trouble if the state proposes an unfunded mandate, she said.

The Delaware State Education Association, the largest union representing school employees, issued a joint statement with Markell backing the legislation. The union would like to make sure that includes work on student-teaching experiences and mentoring for new teachers, union President Frederika Jenner said.

Staff reporters Doug Denison and Matthew Albright contributed to this story.

Contact Nichole Dobo at 324-2281 or ndobo@delawareonline.com. On Twitter @NicholeDobo.

EDUCATION BILL

Delaware has a school choice system, which means a student can apply to attend charter, vo-tech or traditional schools different from their default feeder school. House Bill 90, introduced by Rep. Kimberly Williams, would create a unified application process for applying for a different school.

5-3-13
NJ

» LEGISLATURE

Senate OKs new standards for future educators

The Delaware Senate voted unanimously on Thursday to pass a bill that attempts to increase standards for teacher preparation at Delaware colleges and universities. The bill heads to the House for consideration.

The measure, a highlight of Gov. Jack Markell's State of the State address in January, would set a minimum grade-point average requirement for students hoping to study education in Delaware. Students generally would have to carry a 3.0 grade-point average in their most recent two years of coursework.

The bill also expands data reporting on teacher outcomes and requires them to pass a test, similar to a bar exam, before being certified to teach in a state school. Sponsored by Sen. Dave Sokola, D-Newark, the legislation requires the state's education programs to collect and publicly report data on the performance of their graduates.



**U.S. Department of Justice
Civil Rights Division
Educational Opportunities Section**

AB:RW:JF
DJ 169-85-23

U.S. Mail: 950 Pennsylvania Avenue, NW
Patrick Henry Building, Suite 4300
Washington, DC 20530
Overnight Mail: 601 D Street, NW
Suite 4300
Washington, DC 20004
Telephone: (202) 514-4092
Facsimile: (202) 514-8337

April 9, 2013

By Electronic and U.S. Mail

Tony Evers
State Superintendent
Wisconsin Department of Public Instruction
P.O. Box 7841
Madison, WI 53707-7841

Dear Mr. Evers,

Thank you for facilitating our meeting on December 12, 2012 with officials from the Department of Public Instruction ("DPI"). The purpose of the meeting was to discuss DPI's obligation under Title II of the Americans with Disabilities Act of 1990 ("Title II"), 42 U.S.C. §§ 12131-12134, to ensure that students with disabilities who seek to attend voucher schools through the Milwaukee Parent Choice Program ("MPCP" or "school choice program") do not encounter discrimination on the basis of their disability status. As you are aware, advocacy groups in Wisconsin have alleged that students with disabilities in the Milwaukee Public Schools ("MPS") are (1) deterred by DPI and participating voucher schools from participating in the school choice program, (2) denied admission to voucher schools when they do apply, and (3) expelled or constructively forced to leave voucher schools as a result of policies and practices that fail to accommodate the needs of students with disabilities. Our position, consistent with interviews of parents and public school district officials, is that DPI must do more to enforce the federal statutory and regulatory requirements that govern the treatment of students with disabilities who participate in the school choice program.

At the December 12 meeting, DPI provided assurances that it is committed to administering the school choice program in accordance with all applicable state and federal requirements, and requested that the United States enumerate in writing the specific measures that must be implemented to comply with federal law. This letter is intended to provide DPI notice of its legal responsibilities as the agency charged with administering and overseeing the school choice program, and to set forth a process to ensure DPI's compliance with federal law.

Because the school choice program is a public program funded and administered by the State, the State's administration of the program is subject to the requirements of Title II. See 28 C.F.R. § 35.102(a) ("[T]his part applies to all services, programs, and activities provided or made available by public entities."). Title II provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. The regulations implementing Title II require, *inter alia*, that public entities make reasonable modifications in policies, practices, or procedures where necessary to avoid discrimination on the basis of disability. See 28 C.F.R. § 35.130(b)(7).¹

DPI's obligation to eliminate discrimination against students with disabilities in its administration of the school choice program is not obviated by the fact that the schools participating in the program are private secular and religious schools. Indeed, courts recognize that the agency administering a public program has the authority and obligation under Title II to take appropriate steps in its enforcement of program requirements to prohibit discrimination against individuals with disabilities, regardless of whether services are delivered directly by a public entity or provided through a third party. See, e.g., Armstrong v. Schwarzenegger, 622 F.3d 1058, 1066 (9th Cir. 2010); Kerr v. Heather Gardens Ass'n., No. 09-409, 2010 WL 3791484, at *11 (D. Colo. Sept. 22, 2010); Disability Advocates, Inc. v. Paterson, 598 F.Supp.2d 289, 317-18 (E.D.N.Y. 2009), *rev'd on other grounds*, Disability Advocates, Inc. v. New York Coal. for Quality Assisted Living, 675 F.3d 149 (2d Cir. 2012); James v. Peter Pan Transit Mgmt. Inc., No. 97-747, 1999 WL 735173, at *8-9 (E.D.N.C. Jan. 20, 1999); *cf.* 28 C.F.R. §§ 35.130(b)(1)(v); 35.130(b)(3). In short, the State cannot, by delegating the education function to private voucher schools, place MPCP students beyond the reach of the federal laws that require Wisconsin to eliminate disability discrimination in its administration of public programs.

DPI must therefore implement and administer the school choice program in a manner that does not discriminate against children with disabilities or parents or guardians with disabilities.² To effectuate these rights in the specific context of the school choice program, DPI is required under Title II to ensure that its policies, practices and procedures governing the program (1) empower students with disabilities and their parents to make informed decisions during the school selection process; (2) ensure that disability status has no unlawful adverse impact on admissions decisions, and (3) ensure that voucher schools do not discriminate against students with disabilities enrolled in the school, either by denying those students opportunities and

¹ Under Title II, an entity must modify a policy, practice, or procedure unless it can show that the modification "would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7).

² Title II's nondiscrimination requirements do not compel DPI to require that voucher schools affirmatively provide students with disabilities special education and related services pursuant to the Individuals with Disabilities Education Act ("IDEA"). See 20 U.S.C. § 1400, *et seq.* However, a student with a disability who meets the income requirements for the school choice program, and voluntarily foregoes IDEA services in order to attend a voucher school, is entitled to the same opportunity as her non-disabled peers to attend the voucher school of her choice and to meaningfully access the general education curriculum offered by that school.

benefits available to non-disabled students, or by failing to make reasonable modifications to school policies where ADA regulations apply to DPI or participating schools. DPI is further obligated to collect accurate information about all participating schools, fully inform the public about the educational services and accommodations for persons with disabilities available at participating schools, verify that advertisements to potential enrollees are accurate, and ensure that services offered through the school choice program are provided in a manner that does not discriminate on the basis of disability. Finally, because DPI is charged with operating the school choice program, it is responsible for monitoring and supervising the manner in which participating schools serve students with disabilities.³

To this end, DPI must comply with the following requirements:

1. **State's ADA Title II Obligation.** Pursuant to Title II, DPI must eliminate discrimination against students with disabilities or students whose parents or guardians have disabilities in its administration of the Milwaukee Parent Choice Program ("MPCP"), the school voucher program in Racine, and school voucher programs established in any other locality. The private or religious status of individual voucher schools does not absolve DPI of its obligation to assure that Wisconsin's school choice programs do not discriminate against persons with disabilities as required under Title II.
2. **Complaints.** DPI must establish and publicize a procedure for individuals to submit complaints to DPI alleging disability-related discrimination in the school choice program. DPI will furnish copies of these complaints to the United States on December 15, 2013 and June 15, 2014. The United States will independently review these complaints, and DPI's response thereto, to ensure that complaints are being appropriately addressed.
3. **Additional Data Collection and Reporting.** DPI must, by the dates indicated below, gather and produce to the United States in written format information that will enable the United States to determine how and to what extent students with disabilities are being served by voucher schools. The information should be disaggregated by school and include the following: (1) by September 30, 2013, the number of students with disabilities enrolled in voucher schools for the 2013-2014 school year, disaggregated by grade level and type of disability; (2) by September 30, 2013, the number of students with disabilities denied admission to a voucher school for the 2013-2014 school year; (3) by June 15, 2014, the number of students with disabilities who left a voucher school at any time during the 2013-2014 school year to return to the local public school system; and (4) by June 15, 2014, the number of students with disabilities suspended or expelled

³ All private entities that operate as places of public accommodation must also comply with the provisions of Title III of the ADA, unless an exemption or defense applies under the ADA. See 42 U.S.C. §§ 12181, *et seq.* In some cases, private entities that contract or enter into other arrangements to provide services under the auspices of a public program are also subject to the nondiscrimination requirements that govern the program itself, including but not limited to the specific requirements imposed by the administering agency in accordance with Title II. See 28 C.F.R. §§ 35.130(b)(1)(v); 35.130(b)(3).

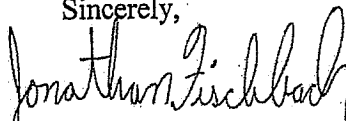
from a voucher school, disaggregated by grade level and type of disability. The United States will review these reports and take appropriate action, pursuant to the ADA and consistent with Department practice, if the information reported reveals actual or potential unlawful discrimination. See 28 C.F.R. § 35.176.

4. **Public Outreach about the School Choice Program to Students with Disabilities.** DPI must conduct outreach to educate the families of students with disabilities about school choice programs, and provide specific and accurate information about the rights of students with disabilities and the services available at voucher schools. DPI shall provide a copy of any existing outreach and informational materials related to the voucher schools, and submit any new and/or revised DPI materials for review to the United States.
5. **Monitoring and Oversight.** DPI must ensure that voucher schools do not discourage a student with a disability from applying for admission, or improperly reject a student with a disability who does apply to a voucher school. DPI must further ensure that voucher schools, absent a valid ADA defense, do not expel/exit a student with a disability unless the school has first determined, on a case-by-case basis, that there are no reasonable modifications to school policies, practices or procedures that could enhance the school's capacity to serve that student. DPI shall report any review, investigation and/or findings of potential unlawful discrimination to the United States, and document the actions taken by the agency to remedy the discrimination.
6. **ADA Training for Voucher Schools.** DPI must provide mandatory ADA training to new voucher schools and to existing voucher schools on a periodic basis, and submit a copy of any training materials and attendance sheets to the United States.
7. **Guidance.** By December 31, 2013, DPI must develop program guidance in consultation with the United States to assist and educate voucher schools about ADA compliance.

These provisions require DPI to amend the policies and practices that govern its oversight of Wisconsin's school choice program for the 2013-2014 school year. At the conclusion of the 2013-2014 school year, the United States will evaluate DPI's compliance with these provisions and identify any additional remedial measures necessary to bring DPI into compliance with federal law. In the event DPI fails to comply with these provisions and/or implement any additional measures necessary to ensure that students with disabilities are not discriminated against in state-administered school choice programs, the United States reserves its right to pursue enforcement through other means.

If you have any questions or concerns, or would like to further discuss this letter, please contact Jonathan Fischbach by phone, (202) 305-3753, or by email at jonathan.fischbach@usdoj.gov. Thank you in advance for your cooperation.

Sincerely,



Anurima Bhargava
Renee Wohlenhaus
Jonathan Fischbach

Educational Opportunities Section
Civil Rights Division

Cc: Janet A. Jenkins, Esq.

May 3, 2013
DE House of Rep
e-Newsletter

Voting Proposals Unveiled

Delaware would become the 12th state to allow Election Day registration if a bill sponsored by a leading House Democrat becomes law.

House Bill 105, sponsored by House Majority Whip Rep. John Viola, D-Newark, would allow eligible residents to register to vote and cast their ballots on Election Day.

Currently, Delaware citizens must register to vote well before the day of the election.

Under the measure, a person would be able to register to vote at his or her polling place on the day of a presidential or state primary or general or special election by showing a valid government-issued photo identification card, current utility bill, bank statement, paycheck or other government document displaying the name and address of the person registering to vote -- the same criteria required for a person registering to vote under existing Delaware law.

However, critics of same-day registration have noted that it can increase costs, overburden poll workers and create delays at polling places that discourage voting.

Neighboring Maryland has also been considering enacting same-day registration. In that state, Election Integrity Maryland (EIM), a non-partisan, non-profit citizen initiative dedicated to fair elections, criticized the proposal. "Proponents of this legislation may scoff at the issue of voter fraud, but they're taking a dangerously narrow view of the problem," said EIM President Cathy Kelleher. "Roughly 75 percent of Americans register great concern for election integrity. ... Minnesota, a same-day registration state, leads the country in cases of voter fraud."

Gov. Jack Markell supports same-day registration and has unveiled a complementary package of administration initiatives to expand the state's e-Signature system and make it possible for citizens to register to vote online.

Delaware voters can currently fill out a voter registration form online, but they must print and submit the form by mail or deliver it to an elections office. Delaware's new online registration system will enable citizens to complete the registration process via the Internet.

House Minority Leader Dan Short, R-Seaford, sounded a note of caution regarding the proposals. "Our caucus members share the opinion that government should encourage eligible citizens to take part in the democratic process, while ensuring that such policies maintain the integrity of the system," he said. "Currently, 39 states do not allow Election Day voter registration and 34 states have not approved online voter registration. Delaware needs to take great care before making any changes in its electoral system that could potentially

undermine the public's faith in the process. We look forward to discussing the aspects of both proposals as they work their way through the legislature."