DISABILITIES LAW PROGRAM

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To: GACEC Policy and Law

CC: SCPD Policy and Law; DDC

From: Disabilities Law Program

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Consistent with council requests, DLP is providing an analysis of certain proposed regulations appearing in the May 2019 issue of the Delaware Register of Regulations and several proposed bills.

Regulations:

1. **Proposed DOE Regulation Regarding Teacher Appraisal Process, 22 Del. Register of Regulations 894, 897 (May 1, 2019).**

The Department of Education is proposing to amend 14 DE Admin. Code 106A Teacher Appraisal Process Delaware Performance Appraisal System Revised and 14 DE Admin Code 107A Specialist Appraisal Process Delaware Performance Appraisal System Revised. These proposals clarify the definitions of "Credentialed Observer" and "Evaluator" and ensure compliance with the *Delaware Administrative Code Drafting and Style Manual.*

A "Credentialed Observer" is redefined as an educator who may conduct observations in addition to those observations completed by an Evaluator. An "Evaluator" is redefined as an administrator who is responsible for a teacher's or specialist's Summative Evaluation. This is a non-controversial amendment and does not require comment.

2. **OCCL Proposed Amendments to Regulations for Child Placing Agencies, 22 Del. Register of Regulations 933 (May 1, 2019)**

The Office of Child Care Licensing ("OCCL") proposes amendments to the Delacare regulations for Child Placing Agencies. The amendments are primarily focused on clarifying the procedures and standards for licensure of placing agencies, as well as the criteria that should be used to evaluate individuals who apply to be foster parents and foster family homes. The summary also states the proposed regulations include "an updated anti-discrimination policy." The analysis below will focus on amendments to the standards for foster family homes. As issues relating to OCCL's anti-discrimination provisions and complaint investigation policies have been reviewed in previous memos, they will not discussed in detail below.

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By way of background, the federal Family First Prevention Services Act ("FFPSA"), passed as part of the Bipartisan Budget Act of 2018 in February 2018, included a provision mandating the U.S. Department of Health & Human Services ("HHS") identify model standards for licensing of foster family homes that could be used by states. The standards recommended by the Children's Bureau of HHS's Administration of Children Families were introduced for comment in the Federal Register in July of 2018. The Children's Bureau acknowledged that it had "relied heavily upon" the model standards formulated by the National Association for Regulatory Administration ("NARA") in crafting the proposed model standards. See 83 Fed. Reg. 37496. The final model standards were announced by an Information Memorandum issued by the Children's Bureau on February 4, 2019 (hereinafter referred to as "the CB Memo").[1] While the standards in this memo are not binding, states were required to submit amendments to their title IV-E plans explaining any deviations from the standards. CB Memo at 3.

The proposed amendments to the Delacare regulations largely replicate language used in the model standards, however are a few specific additions to the eligibility requirements for foster families appearing in both sets of rules that are potentially of concern for individuals with disabilities who wish to become foster parents.

First, the summary of the proposed regulations indicates the intention to require that at least one applicant in a prospective foster family must have "functional literacy," although that term is not defined in the subsequent regulations. The proposed regulations state at 39.19 that in evaluating an application from a potential foster parent, "a licensee shall ensure an applicant is able to read and write." The model standards in the CB memo do not define functional literacy either however the memo further explains that the functional literacy requirement is to "ensure at least one applicant reads and writes at the level necessary to participate effectively in the community in which they live." CB Memo at 4. "[H]aving the ability to read medication labels" is provided as a specific example. *Id.*

The proposed amendments require that licensed agencies have policies to ensure "that the foster parent is able to communicate with the child." See proposed regulations at 26.1.4. This is not explained further. The CB Memo simply states that "[t]he communication standards are flexible in that applicants must be able to communicate with the Title IV-E agency, service providers, and a child in foster care." CB Memo at 4. Additionally in an end note the CB Memo clarifies that the requirement had initially been worded to require communication "'in the child's own language,'" however this language was stricken due to "comments about the availability of communication aids, non-verbal communication and other efforts to address language barriers." CB Memo at 13. While this caveat indicates that American Sign Language and augmentative communication devices could therefore be considered suitable, there is no specific reference to children or foster parents with disabilities in the discussion of communication requirements. Further, the proposed amendments to the Delacare regulations do not provide this guidance. The DLP suggests the addition of language to the requirements regarding literacy and communication to make clear that communication does not have to be "in the child's own language," and that a prospective foster parent could satisfy the requirement with or without the assistance of communication aids, non-verbal communication or other accommodations.

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[1] **The full text of the Children's Bureau memorandum is available at https://www.acf.hhs.gov/sites/default/files/cb/im1901.pdf.**

Another potential concern is that the proposed amendments require in numerous provisions (see, e.g., 39.7) that any history of drug or alcohol abuse or treatment of any family household member must be disclosed (the model standards have the same requirement). This requirement supplements existing language in Delaware's regulations stating an applicant must have "demonstrate[d] emotional stability" as well as "freedom from abuse of alcohol or medications and freedom from use of any illegal drug. See existing text of 39.7. Additionally, the existing regulations require that "a staff member diagnosed with a mental illness that might create a significant risk of harm to children does not work with children until a health care provider states children are not at risk." See existing text of 19.5. Per the definitions provided in the existing regulations a "staff member" includes "an agency employee, contractor or volunteer working more than five days or 40 hours a year." See existing text of 4.0. While it is unclear, this could be read to include foster parents.

Again, there are no further definitions of terms such as "emotional stability" or "significant risk of harm to children" in the regulations, as they exist now or with the proposed amendments, to provide further guidance as to how a licensee should make determinations. This could adversely affect foster families who has a member with a diagnosed mental illness, even if they are receiving appropriate treatment, or is in recovery from substance use disorder, as the regulations could be read to imply that an individual is unsuitable solely on the basis of a history of treatment for mental illness or substance use disorder. The DLP also suggests modifying the proposed language regarding substance abuse and mental health histories to make clear that having such a history is not on its own disqualifying, and identifying factors that should be taken into consideration when determining suitability of a potential foster parent who discloses a history of mental health disorders or substance abuse, or treatment for such conditions.

The existing regulations already state at 50.7 that "[a] licensee shall ensure a disability of an applicant or household member is only considered as it affects the ability to care for a child," however there are no clear guidelines provided in the regulations as to how "functional literacy" should be measured, and how a household member's history of drug or alcohol misuse should be taken into consideration. Although the language in the proposed regulations pertaining to the evaluation of potential foster families is largely duplicative of the federal model standards, without further guidance it is possible that these requirements could be prejudicial to potential foster parents with disabilities. Staff at OCCL and licensed agencies may not be well-trained on issues relating to disability and accessibility, and therefore may be inclined to reject potential foster parents with disabilities based on apparent noncompliance with requirements.

The proposed regulations also require at 40.1.28 that an applicant has "reliable and safe transportation," which is defined to include "a properly maintained vehicle or access to reliable public transportation." This mirrors language in the CB memo regarding transportation. Some advocates see this as a step in the right direction to being more inclusive of potential foster parents, as some states specifically require foster parents to have a motor vehicle. See e.g., *States Are Struggling to Meet Foster Care Needs. New Federal Rules Could Help.* (Dec. 6, 2018), available at https://www.governing.com/topics/health-human-services/sl-foster-care-demands-states-federal-rule.html. The CB memo also notes that all "references to 'only adults in the home' providing transportation" had been removed. See CB Memo at 14, endnote x. This makes clear that in the case of a foster family where the adults in the household cannot drive for whatever reason, transport by third parties could satisfy the requirements. The CB Memo also

clarifies that the "license, insurance and safety restraint requirements apply only to vehicles of applicants, family or friends that are used to transport a child in foster care." *Id.* The DLP suggests the addition of language similar to that used in the CB memo to make clear that "safe transport arrangements with family friends, case workers and teen household members" would comply with the transportation requirements.

The only specific reference to children with disabilities in the proposed amended regulations is in reference to newly imposed limit that there shall be no more than six children in foster care placed in one home. See proposed regulations at 26.23. The rule provides for a number of exceptions, including "[t]o allow a family with special training or skills to provide care to a child who has a severe disability." While this provision on its own is no objectionable, there is not any specific guidance as to what constitutes a "severe disability." The Children's Bureau also declined to define the term "child with a severe disability." See CB Memo at 2. The proposed regulations do not make clear what alternatives could be available in the case that there already at least six foster children placed with the only eligible foster parents who have the necessary training to address a child's specific needs. While certainly the proposed regulations don't *require* that a child with a severe disability be placed with a foster parent even if they already have six or more foster children in their home, there may be many cases where placement in a foster family home with fewer children would be better suited to the child's needs and the additional demands a "severe disability" may place upon a foster parent. The DLP suggests that the regulations should provide a definition of the term "child with a severe disability" and also contain additional language to indicate that such placement would be an individualized determination, and that all available options should be considered in addition to placing a child with severe disabilities in a foster home already at capacity.

Although the proposed amendments mostly mirror language used in the federal model standards, further clarification in certain areas would be helpful to ensure that the requirements are not construed to disqualify potential foster families in which a parent or other household member has a disability, and to clarify placement considerations for children with "severe" disabilities.

3. Proposed Amendment to DDOE Regulation on Initial Licensure for educators, 22 Del. Register of Regulations 899 (May 1, 2019)

The proposed amendment supplements the definition of Performance Assessment. This change does not raise any red flags.

The proposed amendment also amends Sections 3.0 and 7.0, which address requirements for issuance an Initial License. Section 3.3 requires that Initial License applicants, other than an educator licensed in another jurisdiction, meet a list of requirements. It strikes from this list that an individual pass an approved performance assessment within their first two years of the initial license. The proposed amendment correctly removes the performance assessment provision from the requirements for *issuance* of an Initial License. In 2017, the General Assembly passed House Substitute 1 for House Bill 143, which removed the requirement that an individual have passed an approved performance assessment to receive an initial license. Del. H.B. Sub. 1 for H.B. 143, 149th Gen. Assem. (2017).

However, an Initial License holder *is* required to pass a performance evaluation within the first two years of holding their Initial License if they want to be eligible for a Continuing License. *See* 14 *Del. C.* § 1210(c) ("If an initial licensee intends to apply for a continuing license, the licensee shall, prior to the expiration of that initial license, obtain a passing score on an approved performance assessment within the first 2 years of the initial license."); Del. H.B. Sub. 1 for H.B. 143 syn., 149th Gen. Assem. (2017). Therefore, the proposed amendment incorrectly strikes "within the first two (2) years of the Initial License" from subsection 7.2.

The proposed amendment also changes the process for school districts and charter schools to request that the Secretary of Education undertake a review to grant an Initial License to an individual who does not meet the requirements for an Initial License but has otherwise demonstrated effectiveness. The changes require that requests for review be in writing, and identifies which school officials must approve requests for review. The Delaware Department of Education ("DDOE") seeks to amend the functionally equivalent provision in its regulation on Continuing Licenses (*See* analysis of the DDOE's proposed amendment to its regulation on Continuing Licensure). However, instead of requiring that certain school officials *approve* the request for review, it requires that these same school officials *submit* the requests to the Secretary. *Compare* 22 Del. Reg. 899, 901 (Section 16.0) *with* 22 Del. Reg. 901 (Section 16.0). It seems likely that DDOE may wish for consistency. Councils may wish to ask DDOE whether it intends for there to be a difference between in its sections on Secretary review.

Councils may wish support the proposed amendment, except for the removal of the phrase "within the first two (2) years of the Initial License" from subsection 7.2, and ask for clarification about whether DDOE intends for Secretary review requirements to differ between its regulations on Initial Licenses and Continuing Licenses.

4. Proposed Amendment to DDOE Regulation on Continuing Licensure for educators, 22 Del. Register of Regulations 901 (May 1, 2019)

The proposed amendment adds definitions of Performance Assessment and Micro-credential. It also makes minor tweaks to other existing definitions. Micro-credential is a type of professional development. The proposed amendment incorporates micro-credential into Section 13.0, which outlines approved professional development activities that educators may undertake. Additionally, a sentence is removed from subsection 5.4.1, and a substantially similar replacement added to Section 13.0. These changes do not raise any red flags.

Subsection 3.1, which states the requirements an applicant must meet to receive a Continuing License, is amended to include the requirement that the applicant must have passed a Performance Assessment. The inclusion of this requirement is correct, *see* 14 *Del. C.* § 1210(c).

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submit the requests to the Secretary. *Compare* 22 Del. Reg. 899, 901 (Section 16.0) *with* 22 Del. Reg. 901 (Section 16.0). It seems likely that DDOE may wish for consistency. Councils may wish to ask DDOE whether it intends for there to be a difference between in its provisions on Secretary review.

Councils may wish to support the proposed amendments to the regulation, while also asking for clarification about whether DDOE intends for Secretary review requirements to differ between its regulations on Initial Licenses and Continuing Licenses.

Pending Bills

House Bill 120 Rental Tax Credit

This bill is an attempt of offer renters a tax credit, couched in terms of a property tax. It appears to emulate the programs offered by New Castle County to property owners who are elderly or disabled.

Although laudable in concept, the bill is a feeble attempt to offer any genuine relief to renters as the requirements and exemptions will restrict eligibility in all likelihood to a small class of individuals. It is also somewhat disingenuous to use the term property tax or assumed property tax in the bill for reasons stated below.

The bill also contains some ambiguities and inconsistencies that will be enumerated below. In the definitional section (§6602(2)), assets do not include the dwelling for which a property tax credit is sought. Does this mean that an individual can own a dwelling and rent it to himself or herself and claim the credit if otherwise eligible? If not, why is the dwelling that a person is renting mentioned at all in excluded assets?

The definition of an "assumed real property tax" (§6602(3)) is calculated in terms of rent paid, which is a fiction because a person who rents a house or apartment does not pay property taxes because they do not own the property. Individuals who own manufactured homes and rent the lot are assessed property taxes on the value of the manufactured home at the same rate as real property is assessed in the county and school district in which it is located (9 *Del. C.* §8351). However, for these individuals under the bill, their assumed property tax is not based upon the taxes they pay, but again on the lot rent they pay for the lot (or "mobile home pad on which the principal residence of the renter rests"). If individuals who own manufactured homes and rent the lot or pad are to be included in the scope of this bill, their taxes should be based upon the actual taxes paid rather than a fictional property tax calculated on rent paid. Also, although in calculating the assumed real property tax, §6602(3)b. includes taxes paid under Subchapter II of Chapter 85 of Title 9, this reference to the Delaware Code could not be found by the author of this analysis. Subchapter II of Chapter 87 of Title 9 exists and pertains to delinquent taxes. If this is what the bill pertains to, it seems to rewards individuals who did not timely pay their taxes regardless of the reason(s).

The definition of renter in §6601(11) appears to have three (3) eligibility standards. The individual has to be at least sixty (60) years old, or is disabled under several enumerated standards, or if under sixty (60) years old, the individual is below the poverty level, has at least

one dependent child, and does not reside in subsidized housing or public house. However, this section could arguably be read to mean that to be eligible, the individual has to be at least sixty (60) years old and disabled. It would be clearer if an and or an or was placed between a. and b. to clear up any confusion. Further, the disqualification for residing in subsidized or public housing only applies to individuals under sixty (60) and not to those individuals over sixty (60) years old. Some consideration should be given to eliminating this exception in order to make the benefit apply to a larger segment of the affected population.

The bill also lacks details about implementation and administration of the tax credit, delegating these tasks to the Division of Revenue and Department of Finance (§6603(a)). Nothing is mentioned about how the program would be introduced, advertised, or disseminated to the renters in the state. Nevertheless, some guidance would be helpful. Presumably, the eligible individual would get the credit when they filed their state income tax return for the qualifying year. If the person does not have sufficient income which generates a tax liability, this bill would require the individual to still file a tax return to obtain the tax credit. This becomes another requirement for the qualifying individual, who may decide that obtaining the credit is not worth the effort required to obtain same, which could in theory be as little as two dollars ($2.00).

Based upon the above reasons, Councils should request that this bill be amended to eliminate the potential ambiguities and to pertain to a wider section of the population.

HS 1 for HB 123 Limited Guardianship and SCR 30

First, HB 123 should be read in conjunction with SCR 30 which creates the "Non-Acute Patient Medical Guardianship Task Force." HB 123 addresses two fairly disparate concerns. First, it clarifies that the Court of Chancery may craft a guardianship order that is limited in scope or in duration. 3901(d)(2)(b). These guardianships can then be terminated upon application of the guardian, the person or any interested third party.

The intention with this particular section (which is expounded upon in SCR 30) is to allow acute care facilities (though it is not limited to them) to petition for limited guardianship to assist them in discharging individuals. This bill sort of creates a "quickie" guardianship to assist acute care facilities. Acute care facilities can sometimes be "stuck" with patients who no longer require acute care but have nowhere to go, at least absent a payment source. In situations where a person or their family is not cooperating with discharge or with applying for Medicaid or other assistance, this bill would allow the facility and/or the Public Guardian to petition for a limited short term guardian to take over that process (the Public Guardian, it seems). One assumes, but it is unclear, that the patient would still need to meet the legal criteria for requiring a guardian found in 12 Del. Code 3901(a)(2). It would be troublesome to think that a certain subset of individuals could be subject to guardianship irrespective of capacity, or that the fact that a person doesn't apply for Medicaid or cooperate with discharge is *per se* evidence that they meet the definition of "person with a disability" under the guardianship statute.

The bill makes it easier to obtain guardianships, which runs contrary to current trends, at least in other states. This aside, the bill does not address the main root causes for patients being "stuck" in acute care facilities, which among other things are a lack of community services and

placements and discriminatory admissions practices by nursing homes, especially towards individuals who have dementia or behavior issues.

Having said that, the benefit of having limited guardianships explicitly made available is that individuals who do not need plenary guardianships may now be able to avoid them.

The other concern addressed in the bill is broadening the authority of the Office of Public Guardian (OPG) to act as a representative payee or VA fiduciary both for individuals in acute care facilities and for any client of DHSS. This would include any client of DSAMH or of DDDS. The context of this is that DDDS has been a representative payee for numerous clients for many years, and would like OPG to take that over. OPG has expertise to manage the affairs of others, and in some ways having OPG serve as payee makes sense. There is a concern whether OPG will be given appropriate resources to take on this expanded role. The other concern is that the statute allows OPG to decline to serve in any situation where there is a relative who is either able OR willing to serve as a payee. This may put some clients of DDDS (and their families) in a bind, and there is also concern that DDDS ensure that a person who OPG decides not to assist has access to alternative payee services. SSA will stop payment when there is no payee in place for an individual who has been deemed to need one.

Councils may wish to ask for further clarification about whether individuals who are overstaying their discharge at acute care facilities are being subjected to a lesser standard for incapacity under Title 12 and may wish to express concern that the guardianship law is being amended to benefit the health care industry at the expense of individual rights. Councils may wish to endorse the law to the extent it authorizes the OPG to act as representative payee or VA fidicuary but also ask that OPG given sufficient resources and that OPG make this service more broadly available.

SB 65 – Creation of the Focus on Alternative Skills Training Program.

This bill establishes the Focus on Alternative Skills Training Program ("FAST"). FAST will provide tuition, up to $9,000, to Delaware residents who have obtained a high school diploma, Diploma of Alternate Achievement Standards, or a Delaware Secondary credential, and have enrolled in an approved non-degree credit certificate program that provides industry-accepted skill training and certification no later than 18 months after graduating high school.

FAST will improve access to alternative skills training programs and provides additional post-secondary opportunities for Delaware students. Councils should support this initiative and consider supporting ways to make the program available to more individuals, including removing the requirement that eligible individuals must have enrolled in an approved program no later than 18 months following their graduation from high school.

SB 71: Pharmacy Benefit Managers and Pharmacy Ownership

Senate Bill 71 proposes to amend Title 18 and Title 24 of the Delaware Code to: 1) prohibit a pharmacy benefit manager from requiring or providing an incentive for an insured individual to use a pharmacy in which the pharmacy benefit manager has an ownership interest; and 2) require that a pharmacy be owned by a pharmacist or majority-owned by pharmacists. Current pharmacy operators and hospital pharmacies that only serve patients and employees would be exempt from this rule.

Pharmacy Benefit Managers:

Pharmacy Benefit Managers (PBMs) are companies that contract with health plans, large employers, and government programs like Medicare and Medicaid to administer their pharmacy benefits. Among other things, PBMs negotiate discounts with drug manufacturers, negotiate costs between pharmacies and health plans, organize a plan's pharmacy network, design formularies, and establish co-pays. They therefore have a significant impact on consumers and determine the availability and prices of prescription drugs. PBMs have come under scrutiny in recent years because of concerns about conflicts of interest, including potential conflicts that arise due to pharmacies owning PBMs or PBMs owning pharmacies. For example, CVSHealth, one of the nation's three major PBMs, operates its own CVS retail pharmacies and mail-order pharmacy. RiteAid owns EnvisionRx, another major PBM. And the largest PBM in the country, ExpressScripts, owns various types of pharmacies.

A PBM merged with a pharmacy is problematic because the PBM has an incentive to steer plan members to its affiliated pharmacies while facing a disincentive to contract with as many pharmacies as possible to create a broad pharmacy network for the benefit of its members. This problem may also increase the costs of medication for consumers. An issue brief by Applied Policy points out that a PBM that owns a specialty pharmacy, for example, may be incentivized to classify more drugs as "specialty" drugs, which are generally subject to higher cost-sharing and can be filled by the PBM's specialty pharmacy. Experts have also characterized combined PBMs-pharmacies as "sweetheart deals" because the entities no longer have an incentive to negotiate with each other or with drug manufacturers in a way that would result in lower prices for consumers.

SB 71 would help curb the ability of PBMs to drive consumers to its own affiliated pharmacies and engage in self-dealing. SB 71 prohibits PBMs from requiring or providing an incentive to an insured individual to use any type of pharmacy in which the PBM has an ownership interest or that has an ownership interest in the PBM.

Requirements for a Permit to Operate a Pharmacy:

This bill would also encourage the establishment of independent pharmacies and prevent additional corporate-owned chains from operating pharmacies in Delaware. Section 2 of SB 71 limits who is allowed to obtain a permit to operate a pharmacy. Permit holders must be licensed pharmacists or entities (including partnerships, corporations, and limited liability companies) that are majority-owned by licensed pharmacists. This part of the bill is modeled after North Dakota's unique Pharmacy Ownership Law and mirrors the language of that legislation. As a result of this law, which was enacted in 1963, North Dakota is the only state that generally has no national chain store pharmacies.

Proponents of North Dakota's Pharmacy Ownership Law argue that it benefits consumers because it has resulted in lower drug prices, more personalized care, and more pharmacies per capita and in rural areas. A 2014 report analyzing the law from the Institute for Local Self-Reliance seems to support these claims. The report notes that for the preceding five years, North Dakota ranked 13th on average in lowest prescription prices among all states. It also describes customer surveys that reveal independent pharmacies tend to receive higher satisfaction scores. Finally, the report highlights that North Dakota has 30% more pharmacies per person than the

national average, and these pharmacies are distributed more evenly throughout the state than pharmacies in neighboring South Dakota. This distribution allows for greater pharmacy access, particularly for those in rural and less populated areas. On the other hand, critics of the Pharmacy Ownership Law have maintained that it decreases choice, convenience, and competition that could lead to lower drug prices.

Here in Delaware, it is unclear how much of an impact SB 71 would have because current pharmacy permit holders would not be subject to the new rules. Unlike the situation in North Dakota, national chain pharmacies already operate in Delaware and would continue to do so. Therefore, all the benefits of North Dakota's Pharmacy Ownership Law that are seen in that state may not materialize in Delaware if it passes a similar law. The presence of corporate-owned pharmacies in Delaware may result in different market dynamics and consequences if a pharmacy ownership law were to go into effect here.

Further, although the bill exempts hospital pharmacies from the ownership requirement, the bill makes no mention of Federally Qualified Health Centers (FQHCs) or other similar community health clinics. Some of these centers may want to offer pharmacy services in the future – and they should be encouraged to do so. Recent studies on "pharmacy deserts" in minority and underserved communities have recommended the integration of pharmacies into community clinics as a way to alleviate pharmacy access barriers. Pharmacy access problems contribute to disparities in health outcomes given the critical role of medications in preventing and treating chronic conditions.

Councils should endorse Section 1 of SB 71 but should consider asking for additional explanation regarding Section 2 and the rationale behind the pharmacy ownership requirement. For example, it would be helpful to know if the bill's sponsors have any evidence or projections about how this new requirement would affect prescription drug prices or geographic distribution of pharmacies in Delaware. Lastly, Councils should ask that the bill also address the needs of FQHCs and other community health clinics to ensure that these centers do not face obstacles in providing pharmacy services.

SB 78 Consent training as part of health education in schools

SB 78 proposes to include a component on consent and healthy relationships in the health education curriculum for grades 7-12 beginning in 2020. School districts and charter schools will be obligated to provide age appropriate evidence-informed instruction on the meaning of consent and respecting other people's boundaries. The bill also includes reporting requirements, both to the DOE and to the Governor and legislature.

Consent is defined as "unambiguous, voluntary and freely given agreement by all participants in each physical act in the course of sexual activity and excludes lack of verbal or physical resistance resulted from the use of force, threat of force or placing another in fear, as well as history of prior dating or relationship, from the definition of consent.

There is more acknowledgement and discussion nationally of the need for youth to be more aware of boundaries and unacceptable behavior as a result of high profile stories about sexual harassment and assault. Mandatory training on these issues is found as part of freshman orientation in most colleges and universities, but experts believe that waiting until a person

reaches the age of majority to address these issues is a mistake given both the prevalence of sexual activity in minors and the serious consequences that can ensue when individuals perpetrate sexual assault or harassment.

Delaware currently provides little guidance to teachers regarding required topics for education on relationships and sexual behavior. Maryland [2] and Colorado have recently enacted statutes requiring the inclusion of information about consent in sex education. Approximately 11 states, including Maryland and Colorado, specifically mandate training on consent.

Well thought out training can assist teens in developing skills to develop healthy relationships and to avoid relationships and behaviors that can be harmful. People with disabilities are statistically much more likely to be victims of sexual assault.[3] Robust sex education is one of the strategies to help teens with disabilities avoid victimization. For this reason alone, Councils should consider endorsing this initiative as an important step in developing skills for Delaware's teens with disabilities.

SB 81: License to Practice Dentistry

Senate Bill 81 proposes to amend Title 24 of the Delaware Code to allow dentists who work for the Division of Public Health to practice under a temporary license. The Delaware Code already allows dentists who practice for Federally Qualified Health Centers (FQHCs) to practice under a provisional license, assuming they meet all the rules to do so. For example, dentists must have completed a residency program or be licensed in another state and have three years of practice experience. A provisional license enables the holder to practice dentistry in Delaware for two years, and it will convert to a full license once the holder passes a practical exam and fulfills other requirements.

This bill has the stated goal of facilitating the Division of Public Health's recruitment of dentists to serve those in need. The Division offers dental services to Medicaid-eligible clients under the age of 21 (as well as CHIP-eligible clients under age 19). Although Medicaid benefits for children include dental coverage, a report from the Centers for Medicare & Medicaid Services (CMS) shows that in 2010, only 44.9% of Medicaid-covered children in Delaware received any type of dental care. One barrier to receiving care is an inadequate number and geographic distribution of dentists who treat Medicaid patients. Low reimbursement rates result in fewer providers willing to serve children who are on Medicaid. SB 81, however, could help increase the availability of dentists for Medicaid-eligible children by making it easier for dental providers who are not yet licensed in the state to work for the Division of Public Health.

Councils should endorse SB 81. This bill will allow qualified dentists who otherwise would not be able to practice for the Division of Public Health to practice under a temporary license and serve children on Medicaid, who are underserved in terms of dental care.

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[2] http://mgaleg.maryland.gov/2018RS/bills/hb/hb0251T.pdf. SB 78 mirrors the Maryland law.
[3] https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=1163&context=jlasc; http://www.ncdsv.org/images/Vera_Sexual-abuse-of-children-with-disabilities-national-snapshot_3-2013.pdf

SB 92 Medicaid Dental Benefit for adults

SB 92 proposes to add dental care to the list of covered services under the Medicaid program by amending Sections 502, 503 and 505 of Title 31. Dental care for adults has long been an optional Medicaid benefit under the federal Medicaid statute. Currently Delaware is one of only three states that do not provide some sort of coverage for dental care for adults. Children can access dental coverage through Medicaid through age 21 (EPSDT). Some states have very restrictive coverage guidelines, only covering emergency services for adults. Most states (35/47) provide more or less comprehensive services, although most are subject to caps and/or have co-pays. The expansion of dental coverage for adults has long been a top legislative priority of SCPD, DDC and GACEC.

SB 92 provides limited coverage of both preventative and restorative dental care for up to $1000 per year, with the possibility of accessing an additional $1500 per recipient (unclear whether per year) through an approval process administered by DHSS. This additional benefit can be authorized on an emergency basis for dental treatments. Recipients must pay a $3.00 co-pay per visit. These co-pays are in line with what other states charge.

According to the American Dental Association Health Policy Institute, one in five low income adults indicate that their teeth are in poor condition. Of this same group, 37% report that they avoid smiling, and 35% indicate embarrassment due to the condition of their teeth. Sixty percent indicate that cost is the primary reason they have not sought out dental care. [4] Consider that poor oral health has psychological costs that can impact not only state of mind but employability.

The mouth is considered the gateway to the body and is an important tool in diagnosing numerous conditions, including diabetes, some cancers, heart disease, HIV/AIDS and kidney disease. Besides causing pain and difficulty eating, poor oral health can lead to heart problems and other organ disease. Studies have shown associations between poor oral health and a number of chronic conditions especially prevalent in low income groups.[5] Oral disease and pain associated with poor oral health leads to expensive emergency room visits. Poor oral health can lead to pre-term birth, low birth weight and pre-eclampsia. In the elderly, tooth loss leads to poor diet. The soft foods that those with tooth loss eat further aggravate decay and disease[6]

Access to appropriate dental care for individuals with intellectual and developmental disabilities is especially important. There are known disparities in the quality of oral health between individuals with I/DD and typically developing individuals.[7] Dental needs for adults with I/DD are complex and are largely very poorly met by existing mechanisms. [8]

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[4] https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/OralHealthWell-Being-StateFacts/US-Oral-Health-Well-Being.pdf?la=en

[5] https://www.asaging.org/blog/mouth%E2%88%92body-connection

[6] https://familiesusa.org/sites/default/files/product_documents/MCD_Cutting-Medicaid-Funding-Updated_factsheet.pdf

[7] https://www.aegisdentalnetwork.com/cced/2017/11/oral-healthcare-for-persons-with-intellectual-or-developmental-disabilities-why-is-there-a-disparity

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3317070/ ; https://www.disabilityscoop.com/2019/05/08/despite-need-dental-elusive/26584/

Councils should consider strongly supporting SB 92 as it aligns squarely with core priorities and will greatly expand this important benefit to many constituencies.