To: **GACEC Policy and Law**

CC: **SCPD Policy and Law; DDC**

From: Disabilities Law Program

Date: **4/9/2019**

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

Final Regulations

1. Final DELACARE Regulations Regarding Early Care and Education and School-Age Centers, 22 Del. Register of Regulations 865 (April 1, 2019)

The Office of Child Care Licensing (OCCL) has published final Delacare regulations concerning the health, safety, well-being, and positive development of children who receive care in early care and education and school-age centers. Councils' comments on the proposed amendments focused on changes needed to ensure that licensed centers comply with the Americans with Disabilities Act (ADA) by meeting the needs of children with disabilities who require medication while in child care.

Councils endorsed the proposed Delacare regulations, but they also requested the following revisions:

- OCCL should require child care centers to inform parents and guardians that they will make reasonable accommodations for children with medication needs.

- The language in Subsection 63.8 should also be modified to more clearly warn child care centers that even if OCCL regulations do not require licensees to administer medication by injections, it may be mandatory to do so under state and federal anti-discrimination laws.

- For complaints under Subsection 12.5, OCCL should promptly refer complaining parties to all appropriate agencies and develop a system for tracking complaints, as well as consider referring disability-related complaints to CLASI.

OCCL incorporated some, but not all, of these recommendations:

- Under Subsection 23.1.13, OCCL added the requirement that parent/guardian handbooks should include policies concerning reasonable accommodations for children with disabilities. However, we had suggested more specific language clarifying that reasonable accommodations extend to the administration of medication, including medication by injections.

- The updated version of Subsection 63.8 provides greater notice to licensees that administering medication via injections may be mandatory under state and federal laws. OCCL modified the language so that it now states that "[t]he administration of medication may be required under State and federal laws even though it is not mandated pursuant to these regulations." This change is a significant improvement over the previous language, which highlighted that OCCL did not require the administration of medication and would only take enforcement action in limited circumstances. The new language addresses our concerns that child care centers may believe they have complete discretion over whether or not to deliver medication by injection.

- OCCL declined to modify Subsection 12.5 to provide greater detail on the complaint process and to create a process for referring disability-related complaints to CLASI.

Overall, the final Delacare regulations regarding early care and education and school-age centers are notable in that they now allow a licensee to administer medication by non-intravenous injection. This change is an important one that will help ensure that child care centers comply with the ADA by meeting the needs of children who require medication by injection, such as children with diabetes who need insulin.

2. Final DELACARE Regulations Regarding Family and Large Family Child Care Homes 22 Del. Register of Regulations 866 (April 1, 2019)

OCCL also finalized the Delacare regulations for family and large family child care homes. These regulations are similar or identical to the regulations for early care and education and school-age centers. The analysis above also applies to these regulations.

3. Final DMMA Regulation Regarding Eligibility, 22 Del. Register of Regulations 859 (April 1, 2019)

DMMA amended Section 17160.1 of the DSS Manual to align with federal policy. Federal Medicaid law protects Medicaid eligibility for certain disabled adults whose disability existed before age 22 and whose receipt of Social Security benefits based on their parent's work record causes them to lose SSI benefits. The previous language of DSSM 17160.1 incorrectly stated that SSI must be received because of a disability that began before age 22. However, there is no need to inquire into the basis for receipt of SSI. DMMA removed the erroneous language and made all appropriate changes. The final rule is now consistent with federal law.

4. Final DHSS Regulation Governing Dialysis Centers, 22 Del. Register of Regulations 853 (April 1, 2019)

DHSS received three (3) public comments. Based upon the comments, no changes were made to the regulations and the regulations become effective April 11, 2019. Two (2) comments concerned the involuntary discharge policy. They came from the Chairperson of the Governor's Advisory Council for Exceptional Citizens (GACEC) and the Chairperson for the state Council for Persons with Disabilities (SCPD). The comments said that the regulation as written does not provide what is required to be in the involuntary discharge and does not include a follow up with a patient that is involuntary discharged.

The response to these comments said that involuntary discharges would be rare and that the regulations as drafted "adopt" the federal provisions pertaining to dialysis centers, which contain specific requirements for involuntary discharges (42 C.F.R. 494.180(f)).

The third comment came from the Field Vice President of Regulatory Affairs, of Fresenius Medical Care North America (FMCNA). The comments were wide spread, ranging from the financial burden placed on dialysis centers for the cost of the license to whether home programs located in separate space in an in-center provider would require a license, and the application process. The comment raised the question whether dialysis centers that have a modification of ownership (MOC) have to reapply and meet current design and construction standards in effect at the time (the response indicates that they have to meet current standards to protect patient safety). The comment also recommended changing the requirements for a nurse manager (requiring more nursing experience but less experience in maintenance dialysis); the response said the regulations as promulgated match the Centers for Medicare and Medicaid Services (CMS) requirements for nurse managers.

Although the concerns raised by the comments were legitimate, the responses to them were terse and to the point, resulting in no changes to the regulations.

Proposed Regulations

1. Proposed DDOE Regulation on Education of Children and Youth Experiencing Homelessness, 22 Del. Register of Regulations 832 (Apr. 1, 2019)

The McKinney Vento Homeless Education Assistance Improvement Act, 42 U.S.C § 11431 et seq., ("McKinney Act") requires State and Local education agencies to provide certain protections to "homeless children and youths" in order to receive federal funding under the Act. The federal Every Student Succeeds Act ("ESSA") removed children awaiting foster care from the McKinney Act's definition of "homeless children and youths." One protection offered to homeless children and youths [hereinafter homeless students] is a dispute resolution process in the event there is a disagreement about which school a homeless student should attend. The

Delaware Department of Education ("DDOE") proposed amendment to 14 Del. Admin. Code 901 adopts the updated definition of "homeless children and youths." It also a makes, for the most part, non-substantive changes to Delaware's dispute resolution process.

42 U.S.C. § 11432(g)(3)(A) requires homeless students be enrolled, according to their best interests, in either in the school they attended before becoming homeless or, if always homeless, the last school attended (School of Origin) or the school serving the geographic area that the homeless student is currently staying (School of Residence). This amendment does not directly address students with disabilities, although it may affect students with disabilities if they are homeless students. If Councils wish to comment on this proposed amendment, here are few recommendations:

First, Councils may wish to consider recommending that "Best Interest Meeting" be removed from the definitions section. That term is not used in the proposed amendment. The proposed amendment uses the term "best interest," but based on context, it is referring to the standard by which the placement decision should be made, not a meeting where the decision is made. The definition of "School of Residence" is only used in the definition of "Best Interest Meeting." However, for reasons to be discussed below, Councils may not wish to have this definition stricken as there is a place within the proposed amendment where it would be helpful to include this term.

Second, Councils may wish to recommend amending the definition of "School of Origin." The proposed amendment defines School of Origin as "the specific public school building that the student attended when permanently housed, the school in which the student was last enrolled before becoming homeless or the next receiving school the student would attend for all feeder schools." The phrases "attended when permanently housed" and "before becoming homeless" have the same meaning. In other words, the school a child "attended when permanently housed" would be the same as "the school in which the student was last enrolled before becoming homeless." The McKinney Act defines School of Origin in relevant part as "the school that a child or youth attended when permanently housed or the school in which the child or youth was last enrolled, including preschool." 42 U.S.C. § 11432(g)(3)(I)(i). The first part of the federal definition contemplates the situation where a child was not homeless and then became homeless. The second part of the definition addresses a situation where the child has always been homeless. DDOE's definition of School of Origin could be improved by striking the phrase "before becoming homeless."

Finally, the proposed amendment re-wrote the subsection providing guidance on where a homeless student should be enrolled in the event of a dispute. The current section states that in the event of a dispute, the student will be enrolled in the parent/guardian/relative caregiver/unaccompanied youth's choice of either the School of Origin or the School of Residence. *See* Section 4.1. The proposed amendment just states in relevant part that "the child or youth shall be immediately enrolled in the school in which enrollment is sought" by the parent/guardian/relative caregiver/unaccompanied youth. *See* Section 4.2. The available school placement choices under the McKinney Act are either the School of Origin or the School of Residence. DDOE may wish to clarify the available choices in the proposed amendment by stating the child or youth shall be immediately enrolled in either the School of Origin or the School of Residence, whichever is sought by the parent/guardian/relative caregiver/unaccompanied youth.

In Section 4.5.1 of the proposed amendment, the term "Homeless Youth" should be changed to "Unaccompanied Youth" to reflect the change in name for this category of students, and for consistent use throughout the regulation. "Local" should be added in front of School District in 4.4.1 and 4.4.3.1. In 4.5.7, DDOE may wish to add the phrase "or designee" following "Secretary."

As mentioned, above, most proposed changes to this regulation are non-substantive. The substantive change made was decreasing the number of days parties may submit written statements for consideration in an appeal of a placement decision at the State level from 20 business days to 15 business days. While the downside of this is that it could limit participation, it may also result in faster dispute resolution. Based on the McKinney Act, it looks like DDOE has wide latitude when designing the dispute resolution process. Therefore this change seems appropriate, is not necessary good or bad, and thus may not warrant comment.

This proposed regulation does not directly affect students with disabilities. Assuming Councils wish to comment, they may wish to support the amendment and recommend the following changes:

(1) Strike "Best Interest Meeting" from the definitions section since the term is not used in the regulation.
(2) Amend the definition of "School of Origin."
(3) Amend Section 4.2 in the proposed amendment to clarify that school placement options are either the School of Origin or the School of Residence.
(4) Substitute "Unaccompanied Youth" for "Homeless Youth" in Section 4.5.1 of the proposed amendment.
(5) Add "Local" in front of School District in 4.4.1 and 4.4.3.1 of the proposed amendment.
(6) Add the phrase "or designee" following "Secretary" in 4.5.7 of the proposed amendment.

2. DHCQ Proposed Regulations: Intensive Behavioral Support and Educational Residence ("IBSER"), 22 Del. Register of Regulations 839 (April 1, 2019)

The Division of Health Care Quality ("DHCQ") has proposed amended regulations for Intensive Behavioral Support and Educational Residences, or IBSERs. An IBSER is defined by the current regulations as "a residential facility which provides services to residents with autism, and/or developmental disabilities, and/or severe mental or emotional disturbances and who also have specialized behavioral needs." 16 Del. Admin. C. § 3320-1.0. The proposed amended regulatory definition is more or less the same, but makes clear that the services are to be provided to residents 18 years and over, and that an IBSER should have no more than ten residents.

The proposed regulations are more detailed as far as licensing requirements and procedures. Additionally, in the proposed regulations Section 3.0 adds specific requirements for an IBSER to "maintain and comply with a written policy and procedure manual." (3.1) These policies and procedures must include "behavior support that uses person-centered positive behavior support techniques" (3.2.2) and "implementation and documentation of the person centered plan" (3.2.7). Systems for the reporting and processing of critical incidents (3.2.4) as well as tracking data from these reports to assess trends and "help prevent further incidents" (3.2.3) are also required. The specific requirement of these practices would seem to be a positive development in terms of both ensuring resident safety and providing individualized support that is based on data.

Section 5.0 of the proposed regulations provides specific guidelines for incident reporting and what must be included. Additions in the proposed regulations include more specific requirements for follow-up action, as laid out in 5.5.1.8, and the provision at 5.9 that all reportable incidents must be thoroughly investigated by the IBSER and a written report sent to the department within five days, which mirrors the language in DHSS PM 46. Section 7.0 more explicitly spells out that the residents' rights provisions of the Long-Term Care statute apply to the residents of IBSERs.

Section 8.0 more clearly lays out the resident services to be provided by the IBSER. It specifies that the Specialized Behavior Support ("SBS") plan must be developed "within 5 days of admission to the IBSER." This seems like another positive development as it ensures that a personalized plan is in place as soon as possible, and gives residents and any advocates or representatives a deadline they can hold staff to as far as development of a plan. Also, in the existing regulations the requirements for the SBS plans are mixed in the same subsection with the rules about restraint, and it makes much more sense to have them covered in separately as in the new drafted regulations.

As referenced above, Section 8.6 separately discusses procedures for the use of restraint and reporting of restraints. While the proposed regulations contain mostly identical language as the existing regulations, there is some change at 8.6.13, where the new regulations state that "[a]ny physical intervention not in the approved physician intervention procedure and training manual is prohibited." 8.16.14 then states "[t]he use of any physical intervention technique that is medically contraindicated for a resident is prohibited." This language replaces a list of prohibited techniques provided in the existing regulations at 20.11. This more general language allows for future developments in the evidence and professional standards, but ideally training provided to staff might still cover why some of the particular prohibited techniques are unsafe and not allowed.

Section 9.0 describes requirements for personnel qualifications. The existing regulations differentiate between direct care supervisors and services supervisors, and service supervisors and service workers (see Section 13.0 in existing regulations). The proposed regulations would have uniform requirements for supervisory positions, and do not define "service workers" separately from direct care workers. The DLP is not aware of the original reason for separately categorizing certain types of employees, but the new wording and requirements are more straightforward, and still contain essentially the same requirements as far as educational degrees and experience. Section 9.0 also updates the required staffing ratios to reflect that IBSERs are only permitted to have ten or fewer residents. The updated regulations also do not define ratios depending on how many residents are present in the home at a particular time (as compared with the existing regulations at 13.5); the new requirement is that a minimum of 2 direct care workers must be on site and awake at all times, but the number of workers on duty should be "based upon assessment of the residents' needs." (9.4.6)

At 9.5 the proposed regulations increase the minimum number of hours of orientation training for new hires and volunteers from 15 hours (found at 14.1 in existing regulations) to 40 hours. This makes sense given the challenges presented in the provision of individualized services in this type of setting. The proposed regulations also set a uniform requirement for 40 hours of additional training annually regardless of an employee's position, whereas currently there are different requirements for staff based on how many hours they are working per week. While generally more training for staff is a positive, it is possible that part-time staff could find these training requirements onerous, and staff retention is always a big concern.

DLP supports the approval of the proposed regulations, as they provide more specificity and clarity to DHCQ's requirements for IBSERs, as well as additional language emphasizing behavioral interventions should be individualized

3. Proposed Department of Insurance Regulation Regarding Reporting Medical Management Protocols for Insurance Coverage for Serious Mental Illness and Drug and Alcohol Dependency, 22 Del. Register of Regulations 843 (April 1, 2019)

In accordance with 18 Del.C. §§3343 and 3517U, this Department of Insurance proposed regulation sets forth the format and submission requirements for the mental health parity report that is required to be submitted to the Department of Insurance and the Delaware Health Information Network. Section 3343 and 3578 govern insurance coverage for serious mental illness, including drug and alcohol dependency disorders under individual, group, and blanket health insurance plans. These sections provide that all health benefit plans must include coverage for serious mental illnesses and drug and alcohol dependencies. Most relevant to the proposed regulation, these sections prohibit a carrier from issuing any health benefit plan containing terms that "place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of serious mental health illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan." 18 Del.C. §§3343(b)(1)a and 3578(b)(1)(b).

On September 1, 2018, Senate Bill No. 230, as amended by Senate Amendment No. 1 (SB 230/SA1) became effective. SB230/SA1 requires carriers to submit a report to the Delaware Health Information Network and the Department of Insurance on or before July 1, 2019 and "every year thereafter in which the carrier makes significant changes to how it designs and applies its medical management protocols." SB 230/SA1. The report must describe all non-quantitative treatment limitations (NQTLs) (such as preauthorization requirements) that are applied to mental health treatments and treatment for substance abuse disorders benefits and to all medical and surgical benefits. The report further requires a "Parity Analysis" that describes how the medical management protocols and the NQTLs that are applied to each mental health and substance use disorder benefit are applied on parity with the corresponding medical and surgical benefit within the corresponding classification of benefits.

The proposed regulation adopts a model enforcement mechanism concerning mental health parity reporting developed by the National Association of Insurance Commissioners (NAIC). The regulation's model appears to provide insurers with adequate notice of the data that they are required to provide to demonstrate compliance with federal and state law regulating the administration of mental health and substance abuse coverage benefits.

4. Proposed Regulation Department of Insurance, Medicare Supplement Insurance Minimum Standards, 22 Del. Register of Regulations 846 (April 1, 2019)

This regulation implements the mandate of 18 *Del. C.* §3401 et seq. The main purpose of the regulation is to incorporate the changes contained in the Medicare Access and CHIP Reauthorization ACT (MACRA) as they relate to Medicare Supplement policies. By implementing these changes, the state retains regulatory authority over Medicare supplement products rather than have authority revert back to the federal government. Comments and responses to the regulation are due by May 1, 2019. The changes dictated by MACRA must be adopted by the states to be effective January 1, 2020, so this regulation will be timely. This regulation is comprehensive (38 pages long including the notice, charts, and disclosure statement but repetitive in most respects to the prior regulation) and applies to all Medicare supplement policies and all certificates issued under group Medicare supplement policies issued after the effective date of the regulation.

This regulation amends the existing regulation. The changes implemented in the regulation are taken from the model regulation developed by the National Association of Insurance Commissioners (NAIC).

Section 12 implements MACRA and only applies to individuals who become eligible for Medicare on or after January 1, 2020. To be a newly eligible Medicare beneficiary for purposes of this regulation, the individual must both have turned 65 on or after January 1, 2020, and first become Medicare eligible on or after that date.

For these individuals, they will not be able to purchase Plan C and Plan F, plans that cover claims without the individuals paying any out of pocket expenses. The Medicare Part B deductible for 2019 is $185.00 so these newly eligible individuals will be responsible for paying the deductible. Newly eligible individuals will be able to purchase Plans D and Plan G, which is identical to coverage offered by Plans C and Plan F, save for the deductible. Plan C is redesignated Plan D and Plan F is redesignated Plan G. However, these changes do not apply to employer group coverage.

The regulation also contains an updated chart for Plan F, a new chart for Plan G, and disclosure statements for health insurance policies that duplicate Medicare and are sold to Medicare beneficiaries.

This regulation was prompted by a change in the federal Medicare law and uses the model regulation developed by the NAIC. The crux of the regulation is that it makes individuals who become eligible for Medicare after January 1, 2020 (referred to as newly eligible) responsible for paying the Part B deductible (which is covered in Plan C and Plan F). Delaware needed to implement the changes necessitated by MACRA or it would lose the ability to regulate Medicare supplement insurance policies and they would by default be regulated by the federal government. Delaware has taken the necessary steps to keep authority by promulgating this regulation. This regulation is formulaic and uses the language contained in the model regulation. It was necessary to make these changes so that Delaware retains the ability to regulate Medicare supplement insurance policies issued in the state.

Proposed Legislation

SBs 24 and 59 : Medical Marijuana

Senate Bill 24 amends 16 Del.C. § 4902A to allow patients to qualify for a valid registry identification card to purchase and use medical marijuana for any condition that a physician certifies that medical marijuana would likely provide therapeutic or palliative benefit. The bill also removes the requirement that only certain specialists may certify the use of medical marijuana if the patient is younger than 18 years old. Senate Bill 59 amends Section 4902A to allow nurse practitioners and physician assistants to recommend medical marijuana for patients.

Current law identifies the following as acceptable conditions for which an individual can obtain medical marijuana: cancer, a terminal illness, HIV, AIDS, advanced liver damage, ALS (Lou Gehrig's disease), aggression or anxiety caused by Alzheimer's disease, post-traumatic stress disorder, glaucoma, severe migraines and "a chronic or debilitating disease or medical condition or its treatment" that involves nausea, serious pain, seizures, muscle spasms or wasting syndrome. Current law also only allows "physicians," excluding nurse practitioners and physician assistants, to recommend medical marijuana for patients.

Councils should support this effort to expand patient access to medical marijuana. The National Institute on Drug Abuse reports that medical marijuana benefits individuals experiencing pain and inflammation, helps control epileptic seizures, and assists with the treatment of mental illness and addiction. Allowing medical marijuana for any condition and allowing nurse practitioners and physician assistants to make recommendations for its use gives patients an additional treatment option and allows all health-care practitioners to use their best professional judgment when treating patients.

HB 73: Constitutional Amendment Eliminating Limitations on Absentee Voting

This bill is the first leg of a constitutional amendment that will remove the limitations on who can vote by absentee ballot from the Article V, Section 4A of the Delaware Constitution and empower the General Assembly to "enact general laws providing the circumstances, rules, and procedures by which registered voters may vote by absentee ballot." HB 73, lines 10-11. Currently, the Constitution lists specific circumstances that enable a person to request an absentee ballot. Of particular relevance are "because of his or her sickness or physical disability" and "because of the nature of his or her business or occupation." Del. Const. Art. V § 4A. Although this change nominally eliminates the need for persons requesting absentee ballots to specify a reason for the request, it permits the General Assembly to enact statutes to set the "circumstances, rules and procedures" for absentee ballots. The DLP is unaware of any efforts in the General Assembly to impose restrictions similar to those that now exist. Regardless, the amendment, if it ultimately passes, will allow more flexibility in Delaware's absentee ballot system.

It is important to note that the passage of this bill will not amend the Delaware Constitution. In order for this amendment to become part of the Constitution: (1)HB 73 pass both houses of the Legislature by two-thirds majorities, (2) the amendment must be reintroduced as a new bill after the next general election (i.e., after November 2020), and (3) the new bill must pass both houses of the Legislature by two-thirds majorities. Del. Const. Art. XVI § 1.

If the Legislature intends to introduce absentee ballot restrictions by statute that are functionally identical to the current constitutional restrictions, removing the existing constitutional language still provides an opportunity to improve the current language as it relates to persons with disabilities and persons who provide care for persons with disabilities.

The current provision permits absentee ballots for persons who need them "because of his or her sickness or physical disability." Del. Const. Art. V § 4A (emphasis added). Although the DLP is not aware of any instances persons with a disability requesting an absentee ballot and having that request denied because the person's disability was not considered "physical," the term should be removed. The presence of the term "physical" in the constitutional text might discourage some persons with disabilities who need absentee ballots from requesting them. Moreover, a distinction between "physical" and "mental" disabilities (or however else one might categorize "non-physical" disabilities) serves no practical purpose here. If a person's disability causes them to require an absentee ballot, the type of disability should be irrelevant.

The current provision also permits persons where the "the nature of his or her business or occupation." Del. Const. Art. V § 4A. This provision, which is intended to permit persons who are either away from their district on Election Day due to work or are otherwise unable to get to their polling place on Election Day, is interpreted this as covering "persons providing care to a parent, spouse or child who is living at home and requires constant care." https://elections.delaware.gov/pubs/pdfs/absentee_ballot_application.pdf. It does not appear that this broad interpretation of "business or occupation" has ever been challenged, but it could be argued that the interpretation is too broad. It is likely that the State wants to permit caregivers to obtain absentee ballots and shoehorns them into this section because they do not fit anywhere else. Also, this definition does not cover caregivers who are not parents, spouses, or children (e.g., grandparents, grandchildren, aunts and uncles, close family friends, etc.) If the Legislature were able to set the rules for absentee ballots by statute instead of having to amend the constitution, it would be much easier to create a specific rule for caregivers that would cover all caregivers.

The preceding paragraphs assume that, after the proposed amendment becomes part of the Constitution, the Legislature will seek to enact restrictions on absentee voting similar to what we have now. This may not be the case. While it is possible that the Legislature will seek to impose limits that are different from what we have now, it is impossible to analyze every possible form that those restrictions might take. If the amendment becomes part of the Constitution, and if the Legislature proposes restrictions on absentee voting, the DLP will comment on those proposed restrictions as the bills that contain them are introduced. It is also possible that the Legislature will decide to permit any voter who requests an absentee ballot to receive one without that voter having to provide a reason for the request.

According to the National Conference of State Legislatures, only nineteen states, including Delaware, require voters requesting absentee ballots to provide a reason for the request. http://www.ncsl.org/research/elections-and-campaigns/absentee-and-early-voting.aspx. Of those nineteen, only eleven, including Delaware, require a reason to request an absentee ballot and lack any form of early voting (i.e., either in-person early voting or "in-person absentee voting" wherein a person can apply for an absentee ballot and immediately cast that ballot in one trip to an election official's office). *Id.* Eliminating the requirement to provide a reason for requesting an absentee ballot will benefit persons with disabilities and caregivers in multiple ways. It will simplify the application, remove any doubt from caregivers as to whether they are entitled to request absentee ballots, and ensure that all caregivers that need them are able to request absentee ballots. Additionally, even though we have no evidence that the Department of Elections has required proof of a disability prior to allowing someone to get an absentee ballot, eliminating the need to provide a reason for the request will eliminate any fear that persons with disabilities may have about a possible need to "prove" that they have disabilities.

For the reasons stated above, the DLP recommends that the councils support HB 73 and further recommends that, with that support, the councils indicate a preference that the Legislature permit any voter to request an absentee ballot without the need to provide a reason for the request.

Although not directly related to this bill, there is another voting mechanism worth mentioning while changes to voting are being discussed. At least one state (Indiana), has a mechanism whereby persons who need absentee ballots, but who require assistance completing the ballot and affidavit, can vote by absentee ballot with the assistance of a "traveling board." https://www.in.gov/sos/elections/2402.htm. The traveling board, which includes members of both major political parties, travels to the voter, brings the ballot, and assists voter with filling out the ballot (similar to the way in which a person in Delaware who requires assistance at the polls). Because the assistance is provided by people from both political parties, the risk of improper influence over the voter is minimized. Also, because the traveling board brings the ballot, helps the voter fill out the ballot, and takes the ballot, the process is a simple as possible for the voter. A system like this would benefit persons with disabilities who cannot get to their polling sites and who lack adequate assistance in their homes to be able to complete absentee ballots at home. The councils may wish to encourage the Department of Elections to investigate the Indiana system to see if something similar might be able to be implemented in Delaware.

HB 100: Mental Health Units for High-Risk K-5 Schools

This bill seeks to create funding for mental health units for K-5 schools. As defined in the proposed legislation one "unit" means one full-time counselor, school social worker or licensed clinical social worker for every 250 students, and one full-time school psychologist for every 700 students. According to the bill's preamble, currently "86% of Delaware elementary schools do not employ a school social worker," and although experts recommend a maximum ration of 250 students for every full-time counselor, Delaware's statewide ratio for elementary schools is approximately 580 students to each counselor. According to the bill, any full units must be used in the school that generated the unit, however fractional units may potentially be combined and "used to further increase the amount of mental health services available."

To date, efforts to expand mental health services in public schools have been piecemeal due to limited resources. Currently, the Division of Prevention and Behavioral Health ("DPBHS") has contracted Family Crisis Therapists placed in fifty-two elementary schools throughout the state. These therapists are authorized to work with both children and their families however they are only available in a fraction of Delaware elementary schools. More recently, The Department of Services for Children, Youth and Families (including DPBHS) along with the Department of Education are using a new grant from SAMHSA to pilot what is being called Project DelAWARE in three school districts (Colonial, Capital, and Indian River). The objectives of Project DelAWARE will include additional training for school staff on issues relating to mental health as well as the creation of additional in-school clinician positions. See, e.g., "Delaware Receives $9M Federal Grant to Expand Mental Health Supports in Schools," https://news.delaware.gov/2018/09/24/delaware-receives-9m-federal-grant-expand-mental-health-supports-schools/.

Councils may wish to endorse the bill with some caveats. Councils should encourage the allocation of additional resources toward integrating counseling and mental health services into school environments, as this encourages early intervention and referral to more intensive outpatient services when needed, therefore decreasing the likelihood of a child requiring treatment in an institution setting. Enabling children to access these services in their school without their parents needing to make separate arrangements for appointments and transportation would likely increase the likelihood of a child accessing some form of treatment (the bill refers to a statistic that "youth with access to mental health services in school-based health centers are 10 times more likely to seek care for mental health or substance abuse than youth without access").

The primary concern, however, would be whether there would be enough clinicians with the right training and certifications to fill the roles created by the bill. Across the nation, shortages are being reported in the fields of psychiatry, psychology and social work. Delaware faces particular challenges because there is no in-state medical school, and large parts of the state are very rural. Additionally, following the passage of HB House Bill 311 in the 149th General Assembly, as of June 2019 Delaware will require that all licensed clinical social workers ("LCSWs") have a master's degrees in social work or an approved doctoral degree, and will institute licensing requirements for all social workers practicing in Delaware, both clinical and non-clinical. See 24 Del. C. § 3901, et seq. While these changes were intended to improve quality and accountability in the practice of social work, they may decrease the number of social workers eligible for the positions created by this bill.

Additionally, the extent that there are both additional school staff hired through the allocation of mental health units and the other efforts on the part of state agencies described above are occurring in the same buildings or districts, it is essential that there is good coordination in order to maximize the resources available and serve as many students as possible.

H.B. 101: School-Based Health Centers

Currently all high schools, except charter high schools, are required to have school-based health centers. This bill would amend 14 *Del. C.* § 4126 to require "high needs" elementary schools to have school-based health centers, as well.

School-based health centers offer students free healthcare services from licensed healthcare professionals at or near school. 18 *Del. C.* § 3571G(a). Services vary depending on the center, but they include "comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, referrals to and follow-up for specialty care and oral and vision health services, mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of mental health and substance abuse services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs." *Id.*

Councils may wish to strongly support this bill. Though these centers serve all students, students with disabilities will likely benefit from them. A student may be able to manage their chronic condition without having to leave school and thus may miss less class. Since services are free, low-income students with disabilities may be able to access more care than they otherwise may have. Importantly, mental health screening and treatment can be difficult to access and its provision in school may improve students' outcomes.

Councils may also wish to offer a few suggestions. First, the Councils may wish to ask for clarification on the definition of "high needs elementary school" in § 4126(a)(3)(a),(b). According to the bill, a high needs elementary school is "any elementary school *either*:

(a) in the top quartile in 3 or more of the following:
   1. Percentage of low-income students.
   2. Percentage of English learners.
   3. Percentage of students with disabilities.
   4. Percentage of minority students.

(b) Having 90% of its students classified as low-income, English learners, or minority." (emphasis added).

Quartiles are calculated by arranging your dataset in order from smallest to largest, and then dividing the dataset into four equally sized groups. The top fourth of the dataset will be in the top quartile. In other words, something's quartile is its position relative to everything else in that dataset. It would therefore be helpful to clarify what dataset will be used when determining what counts as the top quartile, e.g. will top quartile be determined by looking at all elementary schools in the State? All elementary schools in a particular county? Within a school district?

Additionally, subsection (3)(b) is ambiguous. It could be read to mean that a school is high needs if low-income, English learners and minority students, in total, comprise 90% of the student body. It also could be read to mean that 90% of the student body must be classified as either low-income or English learners or minority students. The former interpretation is preferable, as it would require more schools to open health centers and would result in more schools receiving start-up funding for the requisite health centers. However, this may not be what the Legislature intended because it would result in a large number of schools being identified as "high needs." If the latter is the intended definition, Councils may wish to suggest changing subsection (3)(b) to "Having 90% of its students classified as <u>either</u> low-income, <u>or</u> English learners, or minority."

Next, Councils may wish to offer the following observations about the definition of high needs elementary schools. First, some students may fit into multiple categories e.g. low income and has a disability. Because of this, one school may have one student that fits into three categories, whereas another school may have three different students that fit into those three categories. Assuming the schools have the same number of students enrolled (an identical denominator), these schools would have the same percentage of students in each category and thus similar quartile rankings even though the latter school has more disadvantaged students than the first school.

Furthermore, smaller schools will have a smaller denominator (the total student body), which may result in a high percentage of students fitting into the identified categories and thus a higher quartile ranking than a larger school, which may have more students in each category but a lower percentage and thus lower quartile ranking. To address both of these situations, it may be good policy to have State-supported health centers for schools with large numbers (but perhaps smaller percentages) of students in the identified categories. One possible way to address this is to add a third subsection stating that a high needs school is also a school with X number of students who are either low-income, students with disabilities, English learners or minority students.

Next, in § 4126(b)(1),(2), the bill states which categories of schools must open school-based health centers. The subsections say that the requirement does not apply to charter high schools, but does apply to vocational-technical high schools, high needs elementary charter schools, high needs elementary schools, and public high schools. 14 *Del. C.* § 4126(b)(1),(2). Vocational-technical schools and charter schools are public schools. 14 *Del. C.* § 503; *see generally* 14 Del. Admin. Code 100.1.1. Therefore, it may be more accurate to change "public high schools" to "non-charter public high schools, including vocational-technical high schools," and then delete vocational-technical high schools from the list.

Relatedly, Councils may wish seek clarification about whether the Legislature intends for the State to bear start-up costs at vocational-technical high schools and high needs charter elementary schools. Subsection (c) reads in relevant part, "the State shall bear the start-up costs for a school-based health center at any public high school or high needs elementary school." Since, in subsections (b)(1),(2), the Legislature identifies charter elementary schools as a different entity than elementary schools and vocational-technical high schools as a different entity than public high schools, subsection (c) could be read as the State will not fund start-up costs for vocational-technical high schools and charter elementary schools. Assuming that is not the intent, subsection (c) could be changed to "the State shall bear the start-up costs for a school-based health center at any non-charter public high school, including technical-vocational schools, or high needs elementary school, including charter elementary schools."

Finally, Councils may wish to offer a minor recommendation:

Change English Learner to English Language Learner. Delaware Department of Education ("DDOE") uses the term English Language Learner, *see* 14 Del. Admin. Code 920. This would ensure a consistent naming convention for the same category of students.

Councils may wish to strongly support this bill while making the following clarifications and recommendations:

(1) Clarify the definition of "high needs elementary school" by asking what dataset will be used for quartile determinations, and by asking whether subsection (3)(b) is intended to include schools where 90 percent of the student body, in total, is comprised of students who are low-income, English learners or minorities *or* whether a school must have 90 percent of its students fall into either the low-income, or

English learner, or minority category to qualify under (3)(b) as a high needs elementary school.

(2) Recommend the Legislature change how it refers to the different types of public schools identified in § 4126(b)(1),(2), and clarify for which types of schools the Legislature intends for the State to cover health center start-up costs. Assuming the Legislature wishes to cover vocational-technical high schools and high needs charter elementary schools, Councils may wish to request the Legislature amend section (c).

(3) Recommend the Legislature add a provision to the definition of high needs elementary schools to allow elementary schools with high numbers (but perhaps low percentages) of students who have disabilities, are low-income, minorities or English Learners to qualify as high needs even if they do not meet either of the other two criteria.

(4) Change "English Learner" to "English Language Learner."

HB 102: Criminal Record Relief for Survivors of Human Trafficking

House Bill 102 proposes to amend §787, Title 11 of the Delaware Code to expand the list of offenses that may be vacated, expunged, or pardoned for a survivor of human trafficking. Human trafficking can be defined as the practice of exploiting a person via force, fraud, or coercion for labor, services, or commercial sexual activity. Currently, the Delaware Code only allows persons "arrested or convicted of prostitution, loitering or obscenity committed as a direct result of being a victim of human trafficking" to file an application for a pardon or expungement or to make a motion to vacate judgment. HB 102, on the other hand, would allow a person arrested or convicted of "*any* crime…committed as a direct result of being a victim of human trafficking" (except for violent felonies) to seek a pardon, expungement, or vacated judgment (emphasis added). This bill also removes the requirement that a motion to vacate judgment be made two years after the person's last conviction and within a reasonable period of time after the person ceases to be a human trafficking victim.

This bill reflects the recommendation of Delaware's Human Trafficking Interagency Coordinating Council, which in 2018 advised the state to expand the list of offenses eligible to be vacated, expunged, or pardoned for persons who committed offenses as a direct result of human trafficking. (See Report on Actions and Recommendations on Human Trafficking in Delaware, available at dhss.delaware.gov/dhss/admin/files/humantraffic_102018.pdf.) Survivors of trafficking are often forced to commit a wide range of crimes by their traffickers. Although statistics are not available about crimes committed as a result of victimization, a 2016 survey by the National Survivor Network found that 91% of trafficking survivor respondents had a criminal record. Even if survivors manage to escape their traffickers, having a criminal record can cause profound harm and keep survivors from achieving stability in their lives. A criminal record can prevent a survivor from securing employment, finding housing, furthering her education, applying for a loan, obtaining immigration relief, and more.

People with disabilities face increased risk of human trafficking. The Office for Victims of Crime Training and Technical Assistance Center has outlined the factors that make individuals with disabilities particularly vulnerable to being trafficked. Some of these factors include:

- Traffickers may seek out people with disabilities to gain access to their Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits.

- Traffickers may target individuals with disabilities, especially those with intellectual disabilities or mental health diagnoses that may make it difficult for them to report abuse. These victims may also face increased skepticism if they do try to seek help.

- Individuals with disabilities may require a caregiver to meet their basic needs, and caregivers may exploit this dependency and become the trafficker. Even if the caregiver is not the trafficker, people with disabilities may be accustomed to an unequal power dynamic in relationships, which can carry over into relationships with abusers.

Councils should endorse HB 102. This bill will greatly expand access to criminal record relief for human trafficking survivors who committed crimes as a result of their victimization. In doing so, this bill will help survivors avoid the far-reaching consequences of a criminal record and help maximize their ability to secure independence and stability.

HB 103: Division of Substance Abuse and Mental Health

This bill seeks to more explicitly define the responsibilities of Division of Substance Abuse and Mental Health ("DSAMH") and encourages the creation of uniform standards for community mental health providers who contract with DSAMH. Currently, the Code does not provide any detailed description of DSAMH's powers or responsibilities beyond "performance of all of the powers, duties and functions… pursuant to Chapters 51, 53, 55, 57, 59 and 61 of Title 16." See 16 Del. Code § 7908. Additionally while there are currently regulations in place dictating licensing standards for substance abuse treatment facilities (see 16 Del. Admin. C. § 6001, et seq.), no comparable regulations exist for community mental health treatment providers, although mental health group homes are covered by regulations issued by the Division of Health Care Quality (formerly the Division of Long-Term Care Residents' Protection).

As amended by the bill, §7908 maintains a general reference to "power, duties and functions" of various parts of Title 16 of the Code, but updates the relevant chapter numbers to add Chapter 22 (pertaining to the Substance Abuse Treatment Act) and Chapter 50 (dealing with involuntary civil commitments) and removing Chapters 53 (Governor Bacon Health Center) and 57 (sterilization). The amended statute would also enumerate specific powers and duties of DSAMH, including "[t]he authority to create, implement, and oversee licensing requirements for all mental health treatment programs serving individuals who are 18 years and older" and "[c]oordinate with other divisions within [DHSS] as well as with the Department of Services for Children Youth and Their Families." Other enumerated duties include the provision of educational and training programs, making contracts, operating Delaware Psychiatric Center, acquiring or disposing of real property, and soliciting funds from the state and federal government. It also specifically states that DSAMH shall have the authority "to promulgate rules and regulations to implement this section."

While many of the activities contemplated by the statute are already happening in practice and would logically fall under the broad authority already delegated to DSAMH by 16 Del. Code § 7908 as it is currently written, the DLP does not see any harm in formalizing some of these responsibilities. Also, the bill would update references to the various chapters of the Code relevant to DSAMH's work.

Additionally, having uniform licensing standards established by regulation encourages greater consistency and transparency in what is expected of community mental health providers. The proposed changes to the statute would potentially encourage the creation of more regulations to establish uniform licensing standards for all providers operating under contract with DSAMH. Currently standards for community mental health providers (not including mental health group homes) are largely dictated by contracts between DSAMH and its various providers, and licensure is otherwise given by outside bodies such as the Joint Commission or Commission on Accreditation of Rehabilitation Facilities ("CARF").

For these reasons, Councils may want to endorse the passage of HB 103. Should this bill be enacted into law, Councils should encourage the promulgation of regulations to formalize provider standards as well as eligibility, admission and discharge procedures for community behavioral health services in accordance with Medicaid rules.

HB 104: Behavioral and Mental Health Commission

This bill proposes to narrow the focus of the Behavioral and Mental Health Commission, which was created in 2016 by the passage of SB 245, later codified at16 Del. C. § 5191, et seq. The bill would essentially dissolve the larger Commission as currently contemplated by the statute, but would preserve the "Adult Mental Health Peer Review Subcommittee" detailed at 16 Del. C. § 5194, renaming it the Adult Mental Health Peer Review Commission.

By way of background, the Behavioral and Mental Health Commission was created in large part to encourage continued oversight of the state mental health system following the termination of federal court monitoring pursuant to the settlement agreement in *U.S. v. Delaware*. Following the agreement between the parties in 2011, the state was required to expand community-based service offerings for people with serious and persistent mental illness, and was subject to regular reviews by an appointed Court Monitor, Dr. Robert Bernstein, who issued regular reports on the State's progress. In 2016, the District Court granted a joint motion to dismiss the case previously filed by the U.S. Department of Justice, and Dr. Bernstein's monitoring activities therefore concluded.

In the joint brief the parties filed on October 6, 2016 in support of their joint motion to dismiss, the passage of SB 245 at the end of the 2016 legislative session, creating the Commission, was presented to the Court as a way the State would be ensuring the ongoing oversight of the settlement agreement's target population as well as quality control of the services provided to this population. Additionally, Dr. Bernstein had alluded to the future work of the Commission and its Peer Review Subcommittee multiple times in his final report, issued on September 19, 2016 (see Tenth Report of the Court Monitor at p. 9, 98).

In actuality, the Commission as currently called for by the statute is not active, and to the best of the DLP's knowledge a full membership was never appointed. A single meeting took place on November 27, 2017, and the body was never convened again.

Currently there are multiple bodies at the state level that discuss various aspects of behavioral health in Delaware. The DSAMH Governor's Advisory Council and more recently created Behavioral Health Consortium both have appointed members and hold regular meetings that are open to the public. While a diverse array of issues may be discussed at meetings, neither of these groups are focused on outcomes for adult individuals with serious and persistent mental illness or the efficacy of the network of community services created by the Settlement Agreement.

Practically speaking, the bill would not affect the status quo as the Commission is inactive however an active peer review commission would allow outside review of critical incidents and related data. Although the bill removes the direct references to the Settlement Agreement that currently appear within the statute, it preserves the definition of the target population to be tracked by the Commission, which mirrors the language of the Settlement Agreement. One concern as far as implementation would be that the law as written requires that "to the extent possible, at least 50% of the members must be mental health clinicians licensed to practice in the state, at least 1 of whom must be a licensed physician." This requirement would be unchanged by the proposed bill. DLP has some concerns about requiring that at least half of the membership be clinicians. There are similar bodies functioning at the state level (for example DDDS's Human Rights Committee and the DHSS Mortality Review Committee) that do not have the same requirements as far as membership.

Councils may wish to endorse the passage of HB 104, and swift action to appoint members to an active Commission.

HB 105 – Creating a Step Therapy Exception Process

House Bill 105 creates a Step Therapy Exception Process that allows patients who are required by their insurance company to go through step therapy protocols to, under certain circumstances, bypass step therapy to obtain the initially-prescribed medication. Step therapy requires patients to try less expensive drug therapies before coverage is provided for a drug selected by the patient's health care provider. The process is intended to control costs associated with prescription drugs, but can often undermine the judgment of physicians and can cause adverse or dangerous consequences for patients.

The bill provides that "when coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan, or utilization review entity through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination." The bill then lists the circumstances in which a step therapy shall be expeditiously granted, including when: the required drug will likely cause an adverse reaction by or harm to the patient; the drug is expected to be ineffective based on known clinical characteristics of the patient and the known characteristics of the drug regimen; the patient has tried the required drug while under the patient's current or previous insurance or benefit plan and such drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; the required drug is not in the best interest of the patient based on medical necessity, and; the patient is stable on a drug selected by the patient's health care provider or while the patient was insured by the patient's current or a previous benefit plan.

The bill further provides the criteria to establish a step therapy protocol and requires that such protocols be based on clinical criteria that are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups and are based on peer reviewed studies, research, and medical practice.

Councils should endorse this effort to limit insurers' ability to require step therapy. Step therapy places significant burdens on physicians and patients, and has been shown to have a negative impact on patients, including delayed access to the most effective treatment. This bill is an effective first step toward prioritizing patient care over insurer profit.

DMMA Proposed State Plan Amendment for Pathways Program, 22 Del. Register of Regulations 871 (April 1, 2019).

DMMA expressed its intent to file a state plan amendment with CMS to renew the Pathways to Employment Program optional state Medicaid service under Section 1915(i). This is an application for a five year renewal of the Pathways Employment Program for individuals who are ID/DD, or who have visual impairments, autism spectrum disorder, Asperger's Syndrome, and physical disabilities ages 14-25. This SPA is unremarkable except that it proposes to increase participation from the current 430 individuals to 600 individuals by 2024 and adds data collection and performance measures regarding assessments of eligibility to the Quality Improvement Strategy section.

The Pathways to Employment Program provides significant supports to youth with disabilities[1] leading to competitive employment, and Councils should consider strongly endorsing this application for a five year extension.

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[1] **https://dhss.delaware.gov/dsaapd/files/pathways_presentation.pdf**