

To: GACEC Policy and Law

CC: SCPD Policy and Law; DDC

From: Disabilities Law Program

Date: 2/12/2019

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

Proposed Regulations

- 1. Proposed Division of Public Health Office of Medical Marijuana proposed changes to the Medical Marijuana Code, 22 Del. Register of Regulations 652 (February 1, 2019).**

The Office of Medical Marijuana is making changes to the Medical Marijuana Code. Most of these changes involve the addition of regulations for “Safety Compliance Facilities” to provide quality control testing of medical marijuana and the addition of regulations to permit the production and sale of edible marijuana products at “Marijuana Infused Food Establishments.” Some additional changes are made throughout the Medical Marijuana Code and are discussed in the analysis section. Of particular note, the new regulations change the rules for children in a manner that is mostly consistent with the statute, but those restrictions do not appear to have adequate medical bases.

Most of the new regulations appear reasonable, but the regulations are not well-written. While the DLP does not suggest that the councils comment on style and writing as a general matter, the proposed regulations are, in some instances, written so poorly that they become unclear.

I. Permissible diagnoses and physicians

a. Adults

For adults, the new regulations add diagnoses of terminal illness, seizure disorder, glaucoma, and debilitating migraines to the list of permitted diagnoses. This was done to make the language consistent with the statutory language at 16 *Del. C.* § 4902A(3)(a).

b. Children

The current and proposed regulations significantly limit the diagnoses that will allow children access to medical marijuana by creating a separate list of “pediatric qualifying conditions.”¹ It is unclear on what basis the Office of Medical Marijuana imposes the additional restrictions on children. The underlying statute has identical language but does not contain any medical or policy reasoning for such separate restriction. The new regulation reads:

Pediatric qualifying conditions are limited to any of the following related to a terminal illness; pain; anxiety; depression; seizure disorder; severe debilitating autism; or a chronic or debilitating disease or medical condition where they have failed treatment involving one or more of the following symptoms: cachexia or wasting syndrome; intractable nausea; severe, painful and persistent muscle spasms.

It is unclear why diagnoses such as amyotrophic lateral sclerosis (“ALS”) have been excluded for children but included for adults in both the statute and regulation. The regulation is also poorly written and unclear.

As an initial matter, the term “qualifying conditions” is meaningless. This regulation is within the definition of “Debilitating medical condition,” the language found in the statute. The regulation also fails to define “pediatric.” While it may be intended to mean “under the age of 18,”² the field of pediatrics extends through age 21 and can be further extended in unusual cases.³ More importantly, the eligible diagnoses are unclear. As written, it is unclear if “pain;

¹ Under the current regulations there is no separate definition of pediatric qualifying conditions, but section 3.3.3 provides additional limits for patients under the age of 18 that do not exist for adults.

² See 16 *Del. Admin. C.* § 4470-2.0 (Definition of physician).

³ Hardin, et. al., *Age Limit of Pediatrics*, American Academy of Pediatrics, <http://pediatrics.aappublications.org/content/140/3/e20172151>.

anxiety; depression; seizure disorder; severe debilitating autism”⁴ are only eligible if they are “related to a terminal illness.” Sections 3.3.3.1-3.3.3.3 of the new regulation, as well as the statutory language in 16 *Del. C.* § 4090A(b), clarify the situation but introduce another problem because those sections include “intractable epilepsy” as a separate eligible diagnosis. While “intractable epilepsy” is probably covered under “seizure disorders,” these regulations need to be consistent and clear. As written, they are neither.

The DLP recommends that the councils ask that the “pediatric qualifying condition” definition and Sections 3.3.3.1-3.3.3.3 be rewritten to be consistent with one another and with the statutory language. Additionally, the DLP recommends that the councils recommend that the availability of medical marijuana for minors should be as broad as possible under the statute or at least available for the same diagnoses as adults. It is unclear what the medical or policy basis is for additional restrictions on children and, equally important, children whose doctors believe that medical marijuana is the best treatment for them should be able to access that treatment to the fullest extent allowable by law. Because 16 *Del. C.* § 4906A permits additional diagnoses to be added to the acceptable list of diagnoses, this situation could be corrected without a need for a statutory amendment.

There is a similar problem with the definition of “physician.” In the definition of physician, a “physician” for a patient under 18 years of age is limited to certain types of pediatric specialties. In the definition section, the new regulation adds “pediatric psychiatrist” and “developmental pediatrician” to the eligible types of physicians, BUT section 3.3.3 of the existing regulations does not include these new types of physicians to the types of physicians that can certify a minor for medical marijuana. Additionally, the relevant statute, 16 *Del. C.* § 4902A(12) does not include the additions to the types of permissible pediatric specialties. As such, it is unclear whether the Office of Medical Marijuana has the authority to add these specialties at all. The DLP recommends that the councils ask that the definition of “physician” and Section 3.3.3 be rewritten to be consistent with one another and with the statutory language.

II. Primary Caregiver

⁴ Autism Spectrum Disorder is a recognized diagnosis, “severe debilitating autism” is not. The term is not defined elsewhere in the regulations or code.

Current and new regulations both use the phrase “primary caregiver” in multiple places. The term “primary caregiver” is not defined. It appears from context that “primary caregiver” is being used in place of “designated caregiver,” a term that is defined. The DLP recommends that the councils ask that the regulations be rewritten to use the defined term “designated caregiver” and eliminate the undefined term “primary caregiver.”

III. Hearing Procedures

The new regulations regarding hearing procedures are not written clearly and may result in persons utilizing medical marijuana being denied access to their medication for a significant period of time even if “expedited” procedures are used. The problematic procedures are the ones used when the Department determines that a patient’s registration card shall be summarily suspended without notice.⁵ In such a situation, the patient may request a “record review,”⁶ but the regulations do not require the Department to act within a certain period of time. The patient may also request an appeal, and can request an expedited appeal.⁷ Although the regulations do not explicitly so state, it appears that expedited appeals are only available to resolve summary suspensions. In an expedited appeal, the hearing must be scheduled within 15 days,⁸ and the decision on the hearing must be issued within 30 days after the hearing.⁹ This means that a person whose eligibility has been summarily suspended may have to wait 45 days for the matter to be resolved. This will likely result in the patient being unable purchase their medication. This is too long a period for a person to be deprived of their physician-prescribed medication without a decision. Additionally, it is entirely unclear how the “record review” and the hearing interact and whether they are sequential processes or can move forward concurrently. The DLP recommends that the councils that the councils ask that the record review and hearing regulations be clarified and that the expedited hearing procedures be revised so that a patient whose eligibility was summarily suspended will be able to have a hearing AND receive a decision before they are forced to go without their medication.

IV. On Site Visits

⁵ 16 Del. Admin. C. § 4470-9.2.5.1.

⁶ *Id.* at §§ 4470-9.5.5.1.1-9.2.5.5.

⁷ *Id.* at § 4470-9.5.4.

⁸ *Id.* at § 4470-9.5.4.2.

⁹ *Id.* at § 4470-9.5.4.4.

The current regulations, in a section that the new regulations do not change, permits on-site interviews of patients or caregivers to determine eligibility for medical marijuana.¹⁰ It is unclear why on-site interviews, as opposed to interviews at a Department office, are warranted. The Department is only required to provide 24 hour notice of an interview. Patients are required to provide “immediate access” to “any material and information necessary for determining eligibility.” The requirement to assemble all pertinent information on short notice and have it available immediate inspection may be a significant hardship for persons with mental illness or developmental or intellectual disabilities. The DLP suggests that the councils ask that this section of the regulations be rewritten in such a way that it will meet the Department’s needs without placing undue burden and stress on persons with disabilities.

V. Service Animals

The new regulations for Marijuana Infused Food Establishments prohibits any “animals/pets” in the establishment “during the preparation, packaging, or handling of any marijuana infused food products.”¹¹ Services animals are not pets, but they are animals. As such, this arguably excludes services animals and persons who need them from Marijuana Infused Food Establishments. It should be noted that the exclusion is for the entire establishment, not just the area where the food is being prepared, packaged, or handled. According to the regulation, a service animal could not be present in the establishment in the area where products are sold to customers if the food products were being prepared in an entirely separate area. The Americans with Disabilities Act requires places of public accommodation to permit service animals in most places. It may appropriate to exclude a service animal from certain areas of the establishment where and when food is being prepared, but a blanket ban on animals anywhere in the establishment at any time food is being prepared, packaged, or handled in the establishment is overbroad. As a federal law, the ADA will preempt this regulation, but the state should not promulgate a regulation that is facially in conflict with the ADA. As such, the DLP recommends that the councils ask that this portion of the regulation be rewritten more narrowly to ensure that it complies with the ADA.

¹⁰ 16 Del. Admin. C. § 4470-9.1.

¹¹ 16 Del. Admin. C. § 4470-15.3.

2. Proposed DSS Regulation on Application Process, 22 Del. Register of Regulations 652 (February 1, 2019).

The Division of Social Services (DSS) is proposing to amend the DSS Manual to update the sections on the application process for DSS benefit programs to modernize the language and make it more understandable. For example, the term “food stamps” has been updated to “food benefits.” Most of the proposed changes are not significant substantively, and they do improve the formatting and clarity of the manual. Yet DSS could still make further policy changes to improve the application process and use more accurate terminology concerning language access.

Section 2000 and Right to Same-Day Filing:

The updated version of Subsection 2000(C)(ii) states that DSS will inform applicants of their (1) potential eligibility for assistance; (2) right to an eligibility decision within a reasonable time; and (3) right to appeal any DSS eligibility decision. We recommend that DSS remove the policy of notifying applicants about “potential eligibility for assistance.”

Rather than stating that DSS will inform applicants about their potential eligibility, the DSS Manual should explicitly note that DSS will encourage people contacting a DSS office about benefits to apply on that day. The problem with a policy of informing applicants about potential eligibility is that some applicants might be given erroneous information indicating that they are not eligible for benefits. These applicants might then be dissuaded from completing the application process when they are actually entitled to benefits they critically need. To ensure that DSS is giving all applicants equal opportunity to undergo the eligibility determination process, the DSS Manual should instruct DSS offices to encourage all potential applicants to apply for benefits, regardless of potential eligibility.

Subsection 20001.1 and Application Assistance by DSS

Under Subsection 20001.1(1)(E), “Submitting Applications,” the proposed changes do not adequately address situations in which DSS should help an applicant with the application process. Under federal regulations governing SNAP eligibility requirements, state agencies must ensure that SNAP offices establish procedures that best serve households with special needs,

“such as, but not limited to, households with elderly or disabled members, households in rural areas with low-income members, homeless individuals...households with adult members who are not proficient in English....”¹² The proposed language, however, only states that applicants “[w]ill be assisted by DSS in completing the application process if hospitalized or ill.” This policy is too narrow and should be expanded to require DSS to also assist persons who may be elderly, have a disability, be homeless, speak limited English, or otherwise have good cause for assistance.

Additionally, while the current version of the DSS Manual explains that “[i]f an applicant is hospitalized or is ill, provisions for completing the application process at the hospital or in the client’s home will be made by the local intake office,” the revised version no longer includes this explanation. We urge DSS to specify in the updated manual that DSS will make reasonable accommodations to help individuals with the application process, which may include accommodations to allow completion of the application process (including interviews) at the client’s home or other locations.

Subsection 2000.2 and Language Access for Limited English Proficient (LEP) Applicants

The updated subsection on interviewing applicants with limited English proficiency is an improvement over existing policies, but it still requires significant improvement. DSS’ revised policies now explicitly state that “DSS will offer translation services to applicants who cannot speak English.” They also discuss how the “translator” is “preferably a translator available through the Division’s contracted language services.”

While CLASI supports DSS’ efforts to include policies that clarify that it should offer language assistance services, the proposed language uses incorrect terminology. Translation refers to written language assistance, whereas oral language assistance should be referred to as interpretation.¹³ Further, the term “applicants who cannot speak English” is too simplistic and should be replaced with “applicants who are limited English proficient” or “applicants with limited English proficiency.” The DSS Manual in Section 1000 already includes an accurate

¹² 7 CFR § 273.2(a).

¹³ See p. 5 of “Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs,” US Department of Justice (May 2011), available at https://www.lep.gov/resources/2011_Language_Access_Assessment_and_Planning_Tool.pdf.

definition of “limited English proficient” that tracks the definition used in federal guidance on language access: “Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English may be limited English proficient.” This distinction in terms is significant because, for example, an applicant might be able to generally speak English but might not understand it well enough to undergo an interview without an interpreter. DSS should also provide an interpreter whenever applicants request one.

The proposed language regarding DSS-provided interpreters is also inadequate. It is unclear what DSS means when it notes that an interpreter will “preferably” be one available through a contracted language service. When would DSS use a non-contracted interpreter? Who would DSS consider to be an acceptable alternative? DSS must also include a policy stating that it will not ask friends or family members accompanying LEP applicants to interpret, nor will it require LEP applicants to provide their own interpreters. DSS’ default policy should be to always use certified, trained interpreters.

In sum, Councils should support the formatting and updating of the DSS Manual regarding the application process for DSS benefit programs. However, they should ask DSS for the following changes: (1) replace the policy of informing applicants about potential eligibility with a policy of encouraging anyone who contacts a DSS office about benefits to apply; (2) create more comprehensive policies addressing reasonable accommodations DSS will make for applicants during the application process; and (3) use accurate terminology concerning language access policies and specify that DSS will not require LEP applicants to provide their own interpreters.

3. Proposed DSS Income Reporting Requirements for Child Care 22 Del. Register of Regulations 658 (February 1, 2019).

The Division of Social Services (DSS) is proposing to amend the Division of Social Services Manual in order to comply with the new federal statute and regulations regarding reporting requirements for Child Care eligibility. The federal government recently reauthorized the Child Care and Development Block Grant (CCDBG), the federal block grant program that provides child care assistance for low-income families, through the Child Care and Development Block Grant Act of 2014. Additionally, the US Department of Health and Human Services

published new rules in 2016 providing further clarification on the 2014 law. Among other provisions, the federal regulations establish limits for when eligible families must report a change in circumstance – such as a change in income – to the state. These guidelines are meant to reduce the burden of reporting and promote continuity of care. DSS’ proposed amendments address these updated reporting requirements.

Under the proposed amendments, families must only report changes when the following occurs: (1) their monthly income exceeds 85% of the state median income (SMI) for the household size; or (2) the family experiences a non-temporary change, including the loss of employment, the completion of an education or training program, or a permanent change in state residency.¹⁴ When a family reports a non-temporary change that ends their need for child care, DSS will authorize 90 consecutive days of child care before case closure.

These amendments could be improved in the following ways:

- DSS must explain how it will ensure that reporting requirements do not place an undue burden on eligible families and accommodate the needs of working parents. Federal regulations mandate that when a state agency, as here, chooses to impose additional notification requirements, these requirements “shall not constitute an undue burden on families” and shall (1) not require an office visit; and (2) be able to be fulfilled through a range of notification options, such as phone, email, online forms, and extended submission hours.¹⁵ The proposed amendments, however, make no mention of how DSS will accommodate families who need to report changes.
- Federal regulations also direct states to take into account regular income fluctuations when the family’s income exceeds 85% of SMI.¹⁶ CLASI previously raised concerns that the DSS Manual lacks adequate explanation as to how DSS will prevent fluctuations in income from resulting in the closure of a child care case. We reiterate that concern here. In November 2018, DSS stated it would be developing more comprehensive and

¹⁴ Unlike the requirement to report income that exceeds 85% of SMI (which is mandated by federal regulations), the requirement to report a non-temporary cessation of work, training, or education is an option states may choose to impose. 45 C.F.R. § 98.21(e)(1).

¹⁵ 45 C.F.R. § 98.21(e)(2).

¹⁶ 45 C.F.R. § 98.21(e)(1)(i).

detailed income policies in the near future for child care cases.¹⁷ A more robust income policy addressing fluctuations is needed to ensure that temporary changes do not cause a loss of child care benefits.

- The proposed language about reporting a change in monthly income is imprecise. The proposed policy states: “A family must only report a change in monthly income that exceeds 85% of the state median income (SMI) guideline for the household size.” The policy should instead note that families must only report changes in income that result in their monthly income – not the change in income – exceeding 85% of SMI.
- With respect to the continued authorization of child care for 90 days, the proposed amendments should specify that families will continue to receive at least the same level of assistance during that time period.¹⁸
- DSS should consider extending the 90-day time period for continued authorizations, or at least allow for extensions for reasons such as disability or other good cause. Federal regulations state that after a parent’s loss of work or other non-temporary change, states must offer families at least three months of continued assistance so the parent can find another job or resume job training or educational activity.¹⁹ The proposed amendments do not discuss how DSS will accommodate families in which a parent/caretaker might have a disability or face other barriers that create a need for a longer job search.
- The amendments should also include a policy explaining how DSS will evaluate whether a family has regained eligibility for benefits before closing a child care case after 90 days of continued authorization. According to federal regulations, “[a]t the end of the minimum three-month period of continued assistance, if the parent is engaged in a qualifying work, education, or training activity, with income below 85% of SMI, assistance cannot be terminated and the child must continue receiving assistance until the next scheduled re-determination, or at Lead Agency option, for an additional minimum 12-month eligibility period.”²⁰ DSS should outline how it will ensure continuity of benefits in the circumstances described above. Also, to further promote continuity of

¹⁷ DSS Agency Response to Governor’s Advisory Council for Exceptional Citizens Re: DMMA Proposed Child Care Eligibility Authorization Regulation (22 DE Reg. 264), November 2, 2018.

¹⁸ Federal regulations require continued authorization “at least at the same level for a period of not less than three months....” 45 C.F.R. § 98.21(a)(2)(i).

¹⁹ 45 C.F.R. § 98.21(a)(2)(i).

²⁰ 45 C.F.R. § 98.21(a)(2)(ii).

care, we urge DSS to exercise the option to approve benefits for an additional 12 months rather than until the next re-determination.

In conclusion, Councils should ask DSS to further revise the proposed amendments regarding updated reporting requirements for the child care subsidy program. In addition to making certain language more clear, DSS should develop more detailed policies on the following: (1) how DSS will prevent reporting requirements from becoming an undue burden on families; (2) how DSS will take into account income fluctuations; (3) how DSS will accommodate parents/caretakers (such as those with disabilities) who may require more than 90 days to find another job or resume job training or educational activity ; and (4) how DSS will evaluate whether a family has regained eligibility before closing a child care case after 90 days of continued authorization.

4. Final DMMA Regulation regarding MAGI methodology, 22 Del. Register of Regulations 697 (February 1, 2019).

The Division of Medicaid and Medical Assistance (DMMA) has finalized changes to Section 1600 of the Social Services Manual regarding Medicaid MAGI methodology in order to clarify policies on special income counting rules for children and tax dependents. These policies are meant to align with the federal Affordable Care Act regulations.

DMMA made several revisions in response to CLASI's comments on the proposed version of the amendments. In addition to defining the terms "qualifying child" and "qualifying relative," which have very specific definitions under federal regulations, DMMA added clarifying language to policies describing special income counting rules for children or dependents claimed by someone other than a parent (Subsection 16500.5). DMMA also corrected a significant error in the last sentence of this Subsection: Now, the sentence correctly conveys the rule that, for tax dependents, their MAGI-based income is always counted in determining their own eligibility when determining the total household income of a tax dependent who *is claimed by someone other than a parent*²¹ – not a tax dependent "who is not

²¹ Centers for Medicare & Medicaid Services, MAGI 2.0 Building MAGI Knowledge, Part 2: Income Counting at 11; available at: <https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/part-2-income.pdf>.

living with a parent,” as the sentence previously stated. Finally, DMMA also added explanations of exclusions to the general rules in Subsection 16500.5.

Overall, DMMA addressed all the concerns that CLASI raised in prior comments. As a result, the final policies are more clear, thorough, and will help ensure the correct application of federal MAGI income-counting rules to MAGI Medicaid and Delaware Healthy Children’s Program cases.

5. **HB 48- Unit funding for K-3**

The State funds public schools based upon how many “units” of students are enrolled in the school and school district by the last day of September. How many students comprise one unit depends on the student’s grade level, special education classification, and, for some grade levels, whether the student is enrolled for a full day or a half day. 14 *Del. C.* § 1703, *inter alia*, outlines categories of units, based on grade level, special education classification and full-or-half-day enrollment, and defines how many students comprise one unit. The more students it takes to form one unit, the less funding a school district receives.

The current version of § 1703 states that 16.2 students form one Kindergarten through third grade unit unless the student is categorized as requiring intensive or complex special education, at which point one unit is equal to 6 students (intensive) or 2.6 students (complex). The proposed amendment creates a new unit category: Kindergarten through Grade 3 students that are identified as eligible for basic special education and related services. The proposed amendment would, over the course of four years, gradually lower the number of students that would form one K-3 basic special education unit, which functionally increases funding to schools and school districts with students falling into this unit category. Councils may wish to strongly support this amendment, as it will increase funding to schools and school districts with K-3 students that are identified as requiring basic special education and related services.

State funding for school districts and schools is broken down into three categories called “divisions.” Division I money is used to employ teachers, staff, and administrators.²² Division II

²² 14 *Del. C.* § 1702(a).

is used to finance almost all other school costs.²³ Division III provides additional financial support to school districts.²⁴ How many “units” of students are enrolled in each school district and school on the last day of September impacts how much a school district and school receive from all three of these pots of money. In other words, the number of units affects multiple factors that will impact student experience, e.g. how many teachers/staff a school can hire and how much money a school will receive to purchase books and materials.

Currently, § 1703 contemplates a unit for Grade 4-12 students who are identified as requiring basic special education and related services; each unit is comprised of 8.4 students. However, as mentioned briefly, *supra*, no such category currently exists for K-3 grade students. Currently, one unit is equal to 16.2 students, regardless of whether a student has a disability, unless they are identified as needing intensive or complex special education and related services. This is problematic because students with disabilities, even those that merely require “basic” special education, have additional needs that school districts must address.

There is an ongoing lawsuit alleging that the State is failing to adequately and equitably fund schools, which has resulted in a failure to sufficiently educate students who are low-income, English Language Learners, and/or have disabilities.²⁵ The lawsuit was filed by the American Civil Liberties Union of Delaware (“DE ACLU”) and Community Legal Aid Society, Inc., (“CLASI”) on behalf of two nonprofit organizations, Delawareans for Educational Opportunity, and the Delaware branch of the National Association for the Advancement of Colored People (“DE NAACP”). One shortcoming in the State’s current school funding scheme that Plaintiffs identified in their complaint is the failure to provide additional funding to schools educating K-3 students who require special education services that are neither intensive nor complex. Delawareans for Educational Opportunity v. Carney, 2018 WL 6175677, at *14 (Del. Ch. Nov. 27, 2018). The Plaintiffs allege that inadequately funding this category of students resulted in a failure to identify students for special education and related services, delays in creating and

²³ *Id.*

²⁴ *Id.*; 14 *Del. C.* § 1707.

²⁵ Delawareans for Educational Opportunity v. Carney, 2018 WL 6175677 (Del. Ch. Nov. 27, 2018); Delawareans for Educational Opportunity v. Carney, 2018 WL 4849935 (Del. Ch. Oct. 5, 2018).

implementing Individual Education Programs (IEPs), and lost opportunities to help students catch up academically before they fall “irrevocably” behind.²⁶

Creating a K-3 basic special education unit and defining the number of students that comprise one unit below 16.2 students (the number of students that comprise one K-3 unit now) will allow schools to hire more staff and obtain more funding to meet student needs. The proposed amendment will gradually increase funding by lowering the number of students that constitute one unit until it aligns with the Grade 4-12 basic special education unit; 14.2 students will form one unit for the 2019-2020 school year; 12.2 for the 2020-2021 school year; 10.2 for the 2021-2022 school year; 8.4 for the 2022-2023 school year. While it may be ideal if funding increased immediately for the K-3 basic special education unit, any increase is a step in the right direction.

Councils may wish to strongly support this amendment. Additionally, Councils may wish to offer another suggestion related to funding for students with disabilities. Although this proposed amendment patches a funding hole for one category of students, other children with disabilities that receive services and accommodations under Section 504 of the Rehabilitation Act of 1973 (“Section 504”) rather than the Individuals with Disabilities Education Act (“IDEA”) may be being missed. For purposes of Delaware’s education funding statute, whether a student is classified as requiring basic, intensive or complex special education is based upon the IEP and Delaware Department of Education (“DDOE”) regulations.²⁷ A review of DDOE regulations suggest that students are only included in a disability unit if they have an IEP.²⁸ However, not all students with a Section 504 plan will have an IEP. Schools need funding, and teachers and staff to create and implement successful Section 504 plans. It may be good policy for the State to implement a system to ensure these students’ needs are reflected in the unit system, as well.²⁹

²⁶ Am. Comp. ¶¶ 104-106; Delawareans for Educational Opportunity v. Carney, 2018 WL 6175677, at *14-*15 (Del. Ch. Nov. 27, 2018).

²⁷ 14 Del. C. § 1703(d)(7).

²⁸ 14 Del. Admin. C. 701.1.3.

²⁹ See Delawareans for Educational Opportunity v. Carney, 2018 WL 6175677, at *14 (Del. Ch. Nov. 27, 2018).

Councils may wish to support this proposed amendment, as it will provide more funding to schools and school districts who teach students between grades K-3 that are classified as requiring basic special education and related services. Councils may also wish to ask the General Assembly to consider ensuring schools receive necessary financial support for students with Section 504 plans who do not also have IEPs.

6. HB 39: Same Day Voter Registration

This bill establishes same-day voter registration in the State of Delaware. Under current law, voters must register prior to the “fourth Saturday prior to the date of the election.” 15 *Del. C.* § 2036. This bill changes the deadline to the day of the election and specifically permits voters to register at their polling places by submitting an application and identification with proof of address at the polling place. The bill permits multiple forms of identification including (1) government issued photo identification, utility bills, bank statement, paycheck, and similar documents. The bill also changes the deadline for registrations that are mailed or completed by agencies other than the Department of Elections to require that the registrations be received prior to the deadline (i.e., prior to election day). Voters will still be able to register to vote in advance of the election using all of the means that presently exist.

Although not specifically targeted toward persons with disabilities, this bill will benefit persons with disabilities. The current registration deadline is a significant distance from election day. This can cause persons who might want to register to miss the deadline if they are unaware of the registration deadline. Unlike the date of the election itself, the voter registration deadline is not nearly as well publicized. This bill will prevent that problem. Additionally, the current system requires a two-step process: (1) registration and (2) voting, that occur at separate times and places. Allowing both parts of the process to be completed at the same time and place (i.e., the polling place on election day), eliminates some of the burden on voters. For voters who prefer to register in-person, the ability to do so at their polling place on election day will make the registration process much easier.

Although the minimization of administrative burdens is a good thing, the implementation of same-day voter registration may create accessibility problems for voters with disabilities. Voters attempting to register to vote on election day may require assistance from poll workers,

and some voters may require the registration materials in accessible formats. It will be extremely important for the Department of Elections to consider accessibility when it establishes its procedures for same-day registration at polling sites.

Anything that removes or minimizes administrative burdens to voting is a benefit. For voters with disabilities that cause those administrative burdens to be more burdensome than they are to the average voter, the elimination of the burden is an added benefit. For this reason, the DLP recommends that the councils support this bill and should include in the statement of support a statement noting that it is vitally important for the Department of Elections to consider accessibility when it establishes its same-days registration procedures.

7. SB 17: Insurance discrimination based on genetic information

Senate Bill 17 increases the protection provided by the Genetic Information Nondiscrimination Act of 2008 (GINA). GINA protects individuals from genetic discrimination in health insurance (TITLE I) and employment (Title II).

Specifically, health insurers cannot use genetic information to make decisions about eligibility, coverage terms, or premiums. Health insurers may not request or require individuals to undergo genetic testing; consider family health history or a genetic test result as a pre-existing condition; or to use any genetic information they have to discriminate against the individual.

GINA does not apply to the following: federal employees who receive medical care through the Federal Employees Health Benefits Plans; members of the military who receive care through TRICARE; veterans who receive care through the Veterans Health Administration; and Native Americans who receive care through the Indian Health Service. In addition, GINA does not cover long-term care insurance, life insurance, or disability insurance.

Employers cannot use family health history and genetic test results in making decisions about an individual's employment. Specifically, employers cannot use genetic information in employment decisions such as hiring, firing, promotions, pay, and job assignments. Employers are also prohibited from requesting genetic information or genetic testing as a condition of employment.

GINA provides the minimum level of protection against genetic discrimination. However, states can provide more protection against genetic discrimination. Senate bill 17 is an attempt to broaden GINA to prohibit genetic discrimination in the issuance or renewal of disability insurance and long term care insurance. The bill would amend 18 *Del. C.* §2317. The bill provides that if an insurer requires a genetic test, notice that a test is required be given to the individual. Written authorization to perform the test is also required. The bill applies to everyone seeking disability or long term care insurance.

The bill has a noticeable shortcoming, namely that it does not apply to life insurance. The same arguments that have been advanced with respect to disability and long term care insurance apply equally to life insurance. If life insurance companies were prohibited from using the genetic test results of applicants, genetically at risk individuals would be more willing to have genetic testing. This could lead to earlier medical treatment, resulting in improved health and increased life expectancy of the affected individuals. Other states, including Arizona, Maine, and New Jersey, prohibit genetic discrimination for life insurance and disability insurance policies without actuarial justification. Massachusetts, Montana, and New Mexico prohibit genetic discrimination for life, disability, and long term care insurance policies.

Councils should consider asking the bill's sponsors to amend the bill to also prohibit genetic discrimination in the issuance or renewal of life insurance policies. This would give greater protection to all those individuals who want to have or are considering having genetic testing.

8. Raise the Wage Act, H.R. 582 and S. 150 [January 16, 2019]

Congress has introduced the Raise the Wage Act (H.R. 582) in the United States House of Representatives and a companion bill (S. 150) in the United States Senate. This legislation proposes raising the federal minimum wage to \$8.55 this year and increases it over the next five years until it reaches \$15.00 an hour in 2024. After 2024, this legislation would adjust the minimum wage each year to keep pace with growth in the typical worker's wages. Most relevant for people with disabilities and disability advocates, this legislation would phase out the allowance provided to employers to pay workers with disabilities subminimum wages.

The Fair Labor Standards Act allows employers to pay employees with disabilities “whose earning or productive capacity is impaired by age, physical or mental deficiency, or injury” wages below the minimum wage by applying for special certificates.³⁰ The Raise the Wage Act gradually eliminates the subminimum wage by increasing wages for workers in employment establishments with a special certificate gradually to \$12.85 per hour five years after the passage of the act. As of the date of passage, no new certificates could be issued to any employer that had not already received a special certificate prior to the passage date. Six years after the Act would take effect, all certificates would expire and would have no legal effect.

Proponents of the special certificates created by the Fair Labor Standards Act argue that it offers workers with disabilities a foot in the door of the labor market and gives them the opportunity for skill development, training, and an upward career trajectory. Supporters also fear that the elimination of the subminimum wage means that workers with disabilities will likely receive no wages and will face obstacles in the general labor market.

In reality, the subminimum wage stigmatizes and discriminates against workers with disabilities by devaluing their work and eliminating basic labor protections afforded to other individuals and leaves workers with disabilities vulnerable to abuse. The special certificate policy exposes workers with disabilities to exploitation and seclusion by creating “sheltered workshops, which employ people with intellectual and developmental disabilities to perform manual labor while paying employees as low as less than one dollar per hour.”³¹ Addressing the argument that the elimination of sheltered workshops will cause harm to workers with disabilities, statutes and case law exist to prohibit employer discrimination and require reasonable accommodations in the workplace.³²

In 2016, the Department of Labor’s Advisory Committee on Increasing Competitive Integrated Employment for Individuals with Disabilities recommended phasing out the separate

³⁰ 29 U.S.C. § 214(c)(1).

³¹ Lydia DePillis, *Disabled People are Allowed to Work for Pennies Per Hour – but Maybe not for Much Longer*, *Wash. Post* (Feb. 12, 2016), https://www.washingtonpost.com/news/wonk/wp/2016/02/12/disabled-people-are-allowed-to-work-for-pennies-per-hour-but-maybe-not-for-much-longer/?utm_term=.a0562f1c6226.

³² Americans with Disabilities Act, 42 U.S.C. § 12111-12112(b); Rehabilitation Act of 1973, 29 U.S.C. § 794(a); *Olmstead v. L.C.*, 527 U.S. 581, 597-98 (1999).

subminimum wage.³³ A 2012 report from the National Council on Disability also supported gradually phasing out the use of special certificates under the Fair Labor Standards Act.³⁴ While passage of the Raise the Wage Act is preferable to maintaining the status quo, Councils should consider questioning the lengthy implementation process and ask why a gradual approach is more necessary than providing a livable wage to workers with disabilities as quickly as possible.

9. **DMMA Proposed Renewal of DDDS Lifespan Waiver, 22 Del. Register of Regulations 697 (February 1, 2019).**

DMMA gave notice that intends to file with CMS for a five year renewal of the DDDS Lifespan Section 1915(c) home and community based services waiver.³⁵ The waiver application is here : https://dhss.delaware.gov/dhss/dmma/files/ddds_amended_lifespan_waiver.pdf. The waiver was recently substantially amended to include services for individuals living in family homes. The DDDS waiver historically only serviced individuals living in residential placements.

The most significant changes are as follows:

- The waiver adds a new service, which is Medical Residential Habilitation. DDDS is extending eligibility for residential habilitation to individuals who require medical supports.
- Language allowing individuals enrolled in the DDDS Lifespan to also enroll in Section 1115 DHSP Waiver “in order to receive their acute care benefits”
- New provider types have been added

Primary evaluation is restricted to Appendix C, which describes Participant Services.

DLP makes the following observations regarding the proposed additions:

Residential Habilitation. DDDS is adding a new category called Medical Residential Habilitation which is described as “include[ing] the provision of direct skilled nursing services

³³ Department of Labor, Advisory Committee on Increasing Competitive Integrated Employment for Individuals with Disabilities Final Report; available at: https://www.dol.gov/odep/topics/pdf/ACICIEID_Final_Report_9-8-16.pdf.

³⁴ National Council on Disability Report on Subminimum Wage and Supported Employment; available at: <https://ncd.gov/publications/2012/August232012/>.

³⁵ This is a 300+ page document; DLP geared comments to more significant changes. DLP didn't proofread thoroughly but notes that Inspector General is misspelled throughout and there is a misused apostrophe on page 173 (it's)

and habilitative services and supports that enable a participant to acquire, retain or improve skills necessary to reside in a community-based setting.” These services can be provided in group homes, a supervised or staffed apartment or a shared living arrangement. Residents would be required to need medically necessary direct skilled nursing services that must be performed by an RN or LPN within scope of practice, ordered by a physician. These nursing services must be needed daily and not be amenable to pre-scheduled visits. Nursing services can be provided up to 24 hours a day if necessary; the waiver also says that providers can use one nurse to support more than one person if appropriate. Budgeting language in Appendix I-2 suggests that DDDS will allow staffing of one nurse for three residents in a neighborhood home, and one nurse for two residents in a CLA or SLA. The provider is required to oversee the health care needs of the participant.

Councils may wish to express concern about the following points:

- Shared living arrangements and community living arrangements are not licensed by any health care organization. Neighborhood homes are licensed by DHCQ. SLAs are “credentialed” by DDDS but hands on, direct oversight is minimal. Is it safe to allow skilled nursing services to be provided by in places that are not licensed or overseen by agencies with experience in the provision of health care services?
- A later section indicates that in SLAs that provide Medical Residential Habilitation, the provider must be a registered nurse or an advance practice registered nurse. Councils may wish to question who is providing medical supervision to these nurses or to nurses in other settings. The language suggests that the providers are responsible for overseeing health care. Do the providers have medical directors or a doctor on staff who will provide supervision? If not, who is providing supervision to the medical aspects of care? In the CLA or SLA setting, who is supervising the medical aspects of care?
- The waiver language indicates that nurses providing services in Medical Residential Habilitation “demonstrate the ability to work with individuals with ID/DD with a wide range of intensity of support needs.” There is no discussion of who assesses for this degree of experience nor is there an indication that DDDS will develop specific credentials for these nurses.

Provision of this service will enable some individuals with intellectual disabilities to live in more integrated settings by providing skilled nurses in non-nursing home settings; however, it remains important for there to be sufficient oversight of the care that is provided in this setting, and the waiver document is very short on details on how this will be achieved. SLAs and CLAs should be a particular source of concern because they are not licensed by a health care agency. While there is some utility in getting out from under rigid health facility licensing requirements, it is equally important not to swing so far in the other direction that there is minimal oversight of medical care.

Also related to Residential Habilitation, the waiver states that this service can be provided out of state. The language indicates that DDDS remains responsible for assuring the health and welfare of out of state placements even when onsite monitoring is being done by the local authority. Councils should suggest that DDDS have an articulated robust policy regarding oversight of residents placed out of state. Such a policy is not evident in the waiver (although it may not be the place for it).

Finally, there is language that indicates that “individuals under 21 must access services through EPSDT before the waiver can be accessed.” EPSDT services do not always cover residential services, especially for those who do not carry a behavioral health diagnosis. How are children and youth under 21 to access this service through the Lifespan Waiver? DDDS must recognize that it has a role in providing services to individuals under 21 with ID/DD and that EPSDT services, which often lack care coordination, may not always be a source of comprehensive services for young people with ID/DD.

Home Modifications. Language has been added to allow payment for generators as a home modification under the waiver. Additional language clarifies that providers of this service need to be bonded, insured and have all necessary permits and licenses required by trade. They must also provide a one year warranty for any work done. Councils should consider endorsing these changes.

Supported Living. The waiver adds language requiring supported living providers to be qualified by DDDS and meet DDDS standards. They must also agree to comply with PM46 and

other abuse and neglect processes. Direct care workers are required to be certified through completion of a training program as required by DDDS.

Concurrent Participation Language was added to allow participation in multiple waiver programs. Lifespan Waiver participants will now be able to enroll in DSHP plus for “non-DDDS Lifespan Waiver acute care benefits.” This allows all participants to get non-DDDS services through Medicaid managed care. This may enable participants to access a broader range of providers.