



DISABILITIES LAW PROGRAM

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To: SCPD Policy and Law; GACEC Policy and Law; DDC

From: Disabilities Law Program *YJW*

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Consistent with Council requests, I am providing an analysis of relevant proposed regulations appearing in the May 2018 issue of the Register of Regulations. As requested, I have also included a short review of several bills; at the request of GACEC and SCPD.

Regulations

1. Proposed DDOE School Resource Officer Training, 21 Del. Register of Regulations 851 [May 1, 2018]

DDOE has proposed regulations to implement HB 142 (12 Del code 4112F (d)(1) regarding training for School Resource Officers ("SROs"). HB 142's effective date is 7/1/2018. The legislation is an attempt to improve training of SROs to prepare them for their interactions with students with disabilities. This will hopefully lead to better interactions within the school and help address the trend toward criminalization of student behavior that can often be a manifestation of disability (the school to prison pipeline).

The proposed language regurgitates the language in the statute and does not add to or expound upon the content of any required training. The rationale given is that the statute is "prescriptive." The regulation requires, in general terms:

1. Annual "awareness level training" of SROs:
 - a. Consistent with what required of other school personnel of disabilities awareness and behaviors;
 - b. [including] best practices for de-escalation techniques;
 - c. [including] information on intervention decisions and techniques;
 - d. [including] such other training as is necessary to protect health and safety of students which shall include "basic awareness training" specific to IEPs, FBAs and Behavior support plans.
2. The SRO is required to participate in annual state police or equivalent SRO training or equivalent training provided by policy agency employing SRO.

3. The training is to include a cross reference to the duties and responsibilities of SROs highlighted in the respective MOU between district and police agency.
4. At the beginning of each school year or within 30 days after the “first student day of school,” the SRO will meet with school representative of the assigned building to become familiarized with behaviors related to disabilities that may occur in the school and typical responsive actions.

It is unclear the degree to which DDOE collaborated with GACEC, as required by statute. GACEC submitted comments to a draft form of the regulations. (The response is attached.) The legislation contemplates the issuance of regulations, in coordination with GACEC, that among other things covers “other training as is necessary to protect the health and well-being of students with disabilities *as promulgated in implementing regulation.*” §4112F(d)(1)(d). The regulations do not have to be limited to rehashing what the statute requires; however DDOE appears unwilling to deviate from the express statutory language in these draft regulations in order to flesh out training requirements. Furthermore, DDOE is giving complete discretion regarding training requirements and content to the districts and charter schools. This would appear to be an area where there should be uniformity in training. The knowledge base of SROs should not vary from school to school or district to district. All SROs should have the benefit of robust training in how to interact safely and effectively with students with disabilities.

GACEC and others may wish to suggest that DDOE flesh out some of the other trainings that are necessary to protect health and safety, such as hands on training in appropriate de-escalation techniques and restraints and also require more specificity regarding timelines and content. Councils may wish to consider asking for additional details to be added to the regulations, such as:

1. Adding a durational requirement; the disability-specific training should be at least 8 hours, perhaps. DDOE’s response to this request in preliminary comments was that it is up to the districts and charter schools to determine how much training to provide. The regulation ties the training to what is required for other personnel for “disability awareness and behaviors” in the school. However, there is no reference to any standard describing what that training (disability awareness and behaviors) actually entails.
2. Fleshing out what “awareness level training” means. I believe this is a “term of art” in first responder training; it would be helpful to know what it actually means. Does “awareness” mean basic familiarity or working knowledge? The DDOE indicates that “awareness level training” is described in the statute. This is circular reasoning, and some sort of qualitative standard or definition of “awareness” should be included in the regulation.

3. Require that SROs be updated not only at the beginning of the year but also when new students with IEPs start school throughout the year or when IEPs change throughout the year and the changes are relevant to behavioral interventions. (9.3) Because §4112F(d)(1)(d) requires basic awareness training “specific to IEPs, functional behavior assessments and Behavior Plans,” any time a new student arrives or their IEP changes, SROs should be informed so that they can safely and appropriately respond to any new challenges.
- 2. Proposed Regulation DHSS Long Term Care Medicaid Application Methods, 21 Del. Register of Regulations 860 [May 1, 2018].**

DMMA is proposing to bring Section 20103 of the 16 Del. Admin. Code into compliance with the Affordable Care Act. The proposed rule allows “someone acting responsibly” to apply for long term care Medicaid on behalf of an applicant who is either a minor or incapacitated. Applications can also be filed by the applicant, or by someone in the applicant’s household or family, as defined by code.¹ Additionally, the proposed regulation eliminates the requirement for an in person interview, and, consistent with the Affordable Care Act, requires the acceptance of applications by electronic means, telephone, the mail or in person.

DMMA is obligated to amend current regulations to reflect the simplification of the application process mandated by the ACA. The old requirement of an in –person interview, in particular, was unduly burdensome. Frequently, due to circumstances, applicants need other people to file applications for them. The new regulation reflects this reality. The only potential concern is the term “someone acting responsibly.” This term is not defined in the Delaware regulations² though it appears other places in the federal regulations. It may make sense to link the term to the surrogacy statute or to otherwise limit it. Otherwise, nursing homes and other facilities that have a conflict of interest with the applicant may feel empowered to file applications on behalf of residents or patients in circumstances where it might be against earlier expressed wishes or their best interest. Occasionally, people opt not to apply for LTC Medicaid because of the estate recovery provisions or for other reasons.

I recommend that the Councils consider endorsing the regulation with the recommendation that the term “someone acting responsibly” be defined to exclude individuals or entities who have a conflict of interest or at least require that any entity or individual acting as “someone acting responsibly” has an obligation to act in the best interest of the applicant.

¹ The text of the regulation also needs to be corrected to add a correct citation for the definition of family. I also suggest adding the full CFR citation for the definition of household.

² Missouri defines someone acting responsibly as “ [someone] age 18 or older and with the capacity to enter into a contract and who: 1. Is related to the applicant by blood, marriage, or adoption; OR 2. Is a person who the division reasonably determines has sufficient knowledge of the applicant's circumstances to accurately complete the application, and has an obligation to act in the best interests of the applicant.”

3. DMMA Proposed Amendment to 1115 Waiver to include Institutions for Mental Disease (“IMD”). 21 Del. Register or Regulations 917 [May 1, 2018].

Recent changes in CMS managed care regulations limit IMD stays to 15 days in a month.³ DMMA believes that this restriction will negatively impact treatment options, especially for substance abuse disorders (“SUD”). CMS has now invited states to receive Section 1115 waiver authority to include IMD settings as Medicaid-covered settings for SUD treatment. DMMA has published a Notice that it intends to apply for such a waiver.⁴

Inpatient treatment for SUD is an important element in the state’s overall strategy to address the addiction epidemic in Delaware. It will also allow Delaware to continue to leverage federal Medicaid dollars as it addresses this serious public health issue. Councils should consider endorsing this amendment.

4. DMMA Proposed DSHP Section 1115 Demonstration Waiver Extension Application Request, 21 Del. Register or Regulations 917 [May 1, 2018].

DMMA has issued a notice that it is filing for a five year extension of the Diamond State Health Plan.⁵ DSHP includes mandatory managed care enrollment for all categorically eligible individuals, the Medicaid expansion population, DSHP+ long term services and supports⁶ and the Promise Program. According to the notice, DMMA is proposing no changes to the benefits covered or the groups covered (although the waiver was recently amended to include out of state former foster care youth). Likewise, DMMA is not proposing to alter the delivery system, which is primarily managed care, with FFS carve outs for children’s dental and non-emergency transportation. The waiver was recently amended to include DDDS Lifespan Waiver enrollees in Managed Care, and as mentioned above, an amendment is proposed to include SUD services at IMDs.

The draft is noteworthy in that it references an interim evaluation that shows general success, but that additional efforts may be needed with respect to the PROMISE program and coordination of care for dual eligibles. These conclusions were based on 2016 and 2107 assessments. Councils may wish to follow up with requests for more information on how DMMA will address deficiencies in these areas.

Councils may wish to ask DMMA to increase thresholds for some services. Limits on home modifications under DSHP+ come to mind. Currently, this benefit is limited to \$6000 per

³ Historically Medicaid does not fund IMD for persons ages 21-64. DMMA was allowed to cover some IMD as a cost effective alternative, in the managed care context.

⁴ The proposed amendment can be found: http://dhss.delaware.gov/dhss/dmma/files/dshp1115wavier_draft_sud_amendment.pdf.

⁵ The draft waiver extension application can be found here: http://dhss.delaware.gov/dhss/dmma/files/dshp1115waiver_draft_extension_request.pdf

project, \$10,000 per year, with a \$20,000 lifetime limit. Additionally, stair lifts and elevators are specifically excluded. These limits should be increased to reflect the actual cost of common modifications as well as increasing costs over time. Additionally, some mechanism should be added to cover stair lifts (which do not improve the value of a home or make it more usable to others) in certain circumstances. Particularly in older, urban homes, stair lifts may be the only way to create accessibility and a viable community placement for an individual. Paying for home modifications is a crucial component of home and community based services that prevent institutionalization.

Pending Bills

HS1 for HCR 34 Task Force to Investigate Cost of Special Education

This bill creates a task force to define the reasons behind the “dramatic” recent rise in special education and funding, study the issues related to funding, recommend strategies to reduce costs (the savings from which will be reinvested in special education, yet this will somehow reduce costs) and study and recommend standards and oversight to ensure that programs and services are delivered in a cost effective manner. The Task Force includes many representatives from the DDOE and school administration, four at large members appointed by legislators, one Governor’s appointee, a representative from the teacher’s union, three parents, a representative from GACEC and a representative from the Special Education Strategic Advisory Council.

It is worth noting that the percentage of students in Delaware with IEPs is around 15%, which is entirely consistent with national averages. (see attached document from US DOE). Special education services cost more than traditional services; special education services will continue to represent a fairly large piece of any education budget. The increase nationally and in Delaware of children with special education needs is a complex issue that may be beyond the capacity of this Task Force; they may wish to involve representatives from DPH and other state agencies to gain a better understanding of Delaware’s demographics and trends.

SB 172 with SA 1 School Funding Transparency

This bill requires DDOE to develop a standardized statewide approach to the collection of data related to per pupil expenditures at the school level. The bill then requires DDOE to report this data on online individual school report cards, and on downloadable statewide data files that allow individuals to draw comparisons between schools. These reports also include other information such as average teacher salaries, demographics such as rates of English learners, students living in poverty and numbers of special education students.

The DDOE is required to include community involvement in developing standardized approaches and must hold at least three public meetings. They are obligated to include a broad

range of advocates and interested stakeholders, including a representative of the teacher's union and of the GACEC. (per SA 1).

The-goal of the statewide standardization of data collection and the reporting requirements is to ensure the DDOE publicly reports this information at the school level in a manner that makes it useable for comparison and analysis, a duty they already have under state and federal law. With this information, the goal is to ascertain which schools are getting more or less support, to ensure funding to schools according to need and to learn ways to allocate resources more effectively.

Councils should consider endorsing this legislation in order that the public, policymakers, and stakeholders will have the data needed to assess the efficacy of school funding decisions and address inequities in funding that have led to disparate outcomes for students of color, English learners, students with disabilities, and students living in poverty.

HB 374, with HA 1. Additions to Debilitating Conditions/ Medical Marijuana

This bill in current form adds glaucoma and chronic debilitating migraines to the list of conditions eligible for participation in the medical marijuana program. The original bill also included pediatric autism spectrum disorder and pediatric sensory processing disorder, but these conditions were removed by amendment on 4/27/2018. There is a trend nationally to include ASD to the list of debilitating conditions for medical marijuana, and there are a number of clinical trials being performed to study efficacy. (See attached article) Councils should consider endorsing this bill with the observation that it may be appropriate to add ASD as a debilitating condition in certain cases, as results from these studies emerge.

HB 401- Exempting FDA approved medications from Controlled Substances Schedule

HB 401 seeks to exempt federally lawful FDA approved marijuana containing products from Schedule I of the state Controlled Substances Act. This is being proposed in anticipation of FDA approval of drugs using cannabidiol in the treatment of certain pediatric seizure disorders. Taking such medications off Schedule I will hasten access to the medications once approved and available. This will also improve access to other similar medications that may be approved in the future. Councils should consider endorsing this measure to improve access to effective treatments for serious pediatric seizure disorders.

HS 1 for HB 344- Availability of Alternate Achievement Diploma in DOC Educational Programs

Councils reviewed HB 344 which addresses DOC educational programs last month. HS 1 amendments update language related to current terminology (Diploma of Alternate Achievement Standards) and also adds language to clarify that the Diploma will be made

available as an option for inmates who have been court ordered to compulsory education. These were concerns raised by the Councils last month.

HB 398- DOE Regulatory Authority for DOC Education Program

HB 398 is a companion to HB 344, which empowers the DDOE to issue regulations related to the Prison Education Program. Councils should consider endorsing this provision as it is clear that the program could benefit from regulations.

HB 352- Child Care Provider Administration of Medication

HB 352 authorizes licensed child care providers who have undergone medication training programs to administer non-intravenous injections with the permission of the parent or guardian. This bill supports the regulations reviewed at last month's meetings related to medical accommodations in child care facilities and homes. Children with chronic illnesses such as diabetes and seizure disorders will benefit from this change. The change also reflects the growing understanding that properly trained lay personnel are capable of administering routine medications, which will allow easier and fuller access to community life for children and adults with disabilities. Councils should consider endorsing this bill.

HB 406- Allowing small employers to buy Stop Loss Insurance

This bill allows insurance companies to sell to "stop loss" insurance plans to employers who self-fund their health insurance programs (instead of purchasing health insurance) if the employer have at least 5 employees, the majority of whom are employed within the State at least half of the time. Under current law, "stop loss" plans can only be sold to employers with at least 15 employees. Thus, the law would expand the availability of "stop loss" insurance to employers with between 5 and 14 employees.

Some large employers and, increasingly, some smaller employers, choose to self-fund their health coverage. In so doing, the employer pays the healthcare costs of its employees directly (or through a management company). Because self-funded health insurance plans can create large expenses for the employers if there is high usage or high-cost expenditures (e.g., everyone gets the flu in the same month or an employee needs an organ transplant), there are "stop loss" insurance policies that limit the amount that an employer will need to pay out of pocket to cover healthcare costs.

Allowing smaller employers to purchase stop-loss insurance will make it easier for them to self-fund their health insurance instead of taking part in the larger health insurance market. For an employer, there are several potential benefits. It allows them to offer less costly health coverage to their employees by limiting what the insurance covers. Self-funded health insurance plans do not have to offer the Essential Health Benefits and thus may provide coverage for fewer healthcare services than traditional plans. Younger, healthier employees may be incentivized to

self-fund their health insurance to save money. This puts additional pressure on the traditional health insurance market by removing young, healthy people and making the rest of the market, for lack of a better term, older and sicker. This drives up insurance premiums for everyone in the traditional market. It can destabilize the Affordable Care Act Marketplace.

Actions that encourage additional employers to self-fund their health insurance put pressure on the traditional insurance markets by potentially pulling out the younger, healthier people into the self-funded programs. This can raise premiums and deductibles and effectively cause healthcare to become unaffordable even for those who can theoretically afford insurance. It can destabilize the Affordable Care Act Marketplace.

Moreover, because employers can limit coverage for services in ways that they cannot with traditional plans, persons with disabilities (who are statistically more likely to be high utilizers of healthcare) may be discouraged from working at employers with self-funded health insurance plans because vital services may not be covered. This may keep persons with disabilities out of the workplace and serve as a de facto barrier to employment. Alternatively, individuals may only be able to find work with smaller employers, and accept inferior insurance protections and coverage in order to take the work.

Because of the potential effects on the insurance system, and because of the potential employment effects if more and more employers self-fund their health insurance, the councils may wish to comment on this bill.

HB 400- Election Day Voter Registration

This bill allows voter registration up to the day of election by applying and presenting adequate identification at the polling place. Currently, the deadline for registration is the fourth Saturday prior to the election. This bill will make it easier for voters to register and/or change their polling place due to change of address, and will lead to greater public participation in the voting process, including among voters with disabilities, who disproportionately do not vote in elections. The use of up to date electronic registration data by the Department of Elections will eliminate any risk of fraud. Councils should consider endorsing this legislation, which will provide greater access to the voting process for all voters.

HB 104- Increased DDDS Payment Rates to improve wages of Direct Support Professionals

This bill, introduced last year, requires DDDS to increase its rates paid to providers over time to match a benchmark rate set by OMB in 2014, and since updated, and to adjust those rates in the future. Proponents of the bill indicate that DDDS currently funds at 75% of the benchmark market rate. This negatively impacts the ability to hire and retain personnel, particularly direct support professionals. The inability to attract and retain trained personnel can lead to disruptions in services and quality of care.

The 2018-2019 Legislative and Policy Agenda adopted by the councils and other community groups chose pay raises for attendants and direct support professionals as one of its goals for the year. The current shortage of attendants, personal care workers, home health aides and direct support professionals has a profound impact on the stability and quality of community-based services for people with disabilities in Delaware. Part of this shortage is attributable to the low wages that are paid by providers and by Medicaid –funded programs to these workers. Wages for the state –funded attendant care program are especially low (approximately \$10.75 an hour). Even home health aides only make around \$12.00 an hour.

HB 104 is useful as far as it goes, attacking the problem indirectly, but it does not go far enough as it does not address compensation for workers who are in the attendant care program or who provide attendant services or personal care services through Medicaid-funded programs. Councils should consider asking for amendments that incorporate wage increases for workers across DHSS divisions and settings, or endorse the legislation with the proviso that it does not go nearly far enough in addressing wage issues.