GOVERNOR'S ADVISORY COUNCIL FOR EXCEPTIONAL CITIZENS (GACEC)
GENERAL MEMBERSHIP MEETING
7:00P.M., April 19, 2016
George V. Massey Station, Second Floor Conference Room
516 West Loockerman Street, Dover, DE

MINUTES

MEMBERS PRESENT: Chairperson Robert Overmiller, Dafne Carnright, Carma Carpenter, Al Cavalier, Nancy Cordrey, Cathy Cowin, Jane Donovan, Bill Doolittle, Karen Eller, Ann Fisher, Bernie Greenfield, Terri Hancharick, Brian Hartman, Emmanuel Jenkins, Thomas Keeton, Danna Levy, Karen McGloughlin, Chris McIntyre, Mary Ann Mieczkowski, Jennifer Pulcinella, Ron Russo.

OTHERS PRESENT: Guests: Dan Rich/Wilmington Education Advisory Committee; Dean Betts/DOE; Matt Korobkin/DOE; Dale Matusevich/ DOE; Sandra Miller/DVR; Chris Carlson/self-advocate and Lou Ann Carlson/parent.
Staff present: Wendy Strauss/Executive Director, Kathie Cherry/Office Manager.

MEMBERS ABSENT: Lisa Gonzon, Sonya Lawrence, Keith Morton, Shawn Rohe, Brenné Shepperson, Lavina Smith, Kirstin Wolfington.

Chairperson Robert Overmiller called the meeting to order.

GENERAL MEMBERSHIP MEETING

Robert asked for and received a **motion** to approve the April agenda. **Motion was approved.**
Robert asked for and received a **motion** to approve the March minutes. **Motion was approved.**
Robert asked for a **motion** to approve the March financial report. A **motion was made and approved** to accept the financial report as submitted.

There were no public comments.

Robert then introduced Dale Matusevich for his presentation on transition.

SPECIAL PRESENTATION

Dale Matusevich gave a presentation on State Transition Initiatives. A PowerPoint of the presentation is attached for your reference.

DOE REPORT

Mary Ann Mieczkowski presented the Department of Education (DOE) report which contained the following information:

Inclusion Conference
On March 16th, over 600 professionals in the field of education, parents and community members attended Delaware's 22nd Annual Inclusion Conference at the Dover Downs Conference Center.

The keynote speaker, Dr Phil Strain, spoke on "Inclusion Myths and Realities: Key Findings, Quality Indicators, and Longitudinal Needs for Children."
The six breakout sessions included topics such as: Planning Meaningful Intervention and Measuring Growth, Class Wide Positive Behavioral Interventions and Supports: Foundations and Application, Prevent - Teach - Reinforce with Children Birth to Five: in Preschool and At Home, Students, their Environment, Task and Tools (SETT): A Framework for Assistive Technology Decision-Making, Enhancing Language Learners with Disabilities' Access with Key Language Uses, and Functional eye gaze assessment and language intervention for children who use AAC.

On Tuesday March 15, over 80 parents and community members attended the family event for the Inclusion Conference at Dover Downs. Dr. Phillip S. Strain, University of Colorado Denver, provided ways parents could work with their child at home to reinforce positive behavior.

DELAWARE STATE CHAMBER OF COMMERCE NAMES
Project SEARCH – New Castle County a 2016 SUPERSTARS IN EDUCATION AWARD WINNING PROGRAM

Project SEARCH – New Castle County
Red Clay Consolidated School District
Project SEARCH is a nine-month school-to-work collaborative transition program for students 18-21 with intellectual and developmental disabilities. The program operates entirely within a

host business (Christiana Care Hospital). Total workplace immersion facilitates a seamless combination of classroom instruction, career exploration and on-the-job training and support.

Superstars in Education is charged with recognizing outstanding educational programs and individual achievements. The Superstars in Education Selection Committee considered 42 nominations from traditional public, private, magnets, charters and parochial schools from around the state. Six winners were selected to be honored this year.

Delaware Selected as 1 of 7 States to receive intensive technical assistance (TA) from the National Technical Assistance Center on Transition (NTACT).
The National Technical Assistance Center on Transition (NTACT) has announced that Delaware has been identified for intensive technical assistance (TA) from NTACT. NTACT is committed to supporting state needs to improve outcomes for youth with disabilities. The Office of Special Education Programs (OSEP), Rehabilitation Services Administration (RSA), and NTACT will be working with Delaware to improve transition services for students with disabilities to ensure career and college readiness.

As a participating state, Delaware will be anticipating the following outcomes as a result of this intensive TA:

- Improved capacity to provide educators and VR service providers with knowledge of and skills to deliver, evidence-based and promising practices (EBPPs);
- Improved participation of students with disabilities in academically rigorous and career relevant curricula that prepare them for postsecondary education and employment;
- Improved collaboration between SEA and VR agencies to enhance services for students with disabilities.
- Improved capacity to analyze and use relevant data to identify systemic concerns and guide and evaluate the effectiveness of EBPPs.

- Increased knowledge and implementation of EBPPs to reduce dropout rates and improve graduation for students with disabilities, including the use of early warning systems.

SourceAmerica Design Challenge Announces High School and Collegiate Winners of Annual Engineering Competition

National competition highlights productivity of employees with disabilities through assistive technology:

Duke University placed first in the SourceAmerica College Design Challenge, a national engineering competition to address employment issues faced by individuals with disabilities. Concord High School of Wilmington, Delaware, won the high school division of the challenge. Duke's multidisciplinary team was recognized for its innovative device called Hanging with DECI. The team worked with Durham Exchange Club Industries (DECI) to modify two work tasks— straightening wire hangers and opening pill bottles—to minimize the need for complex movement and evaluation skills. Three devices were designed and built: a hanger straightener and two bottle openers. All three devices showed improvements in productivity and made the jobs accessible to those who were not previously able to perform the tasks.

Concord High's multidisciplinary team was recognized for its innovative device, The Scan 'n Sort, a barcode scanning device that alphabetically categorizes recycled medicine making sorting in pharmacies easy for employees with disabilities.

Senate Bill 180 - Age of Majority
Passed both the House and Senate last week

Robert thanked Mary Ann for her report.

Council members were then reminded of the changes to the Bylaws that were shared at the last meeting and sent to all Council members for review.

A **motion** was made and **approved** to accept the proposed changes to the Council Bylaws.

DIRECTORS REPORT

Wendy discussed the Senate Joint Resolution (SJR) 4 meeting. The final report is now due on June 30, 2016. Wendy shared that the Joint Strategic Planning Retreat with the Developmental Disabilities Council (DDC) and State Council for Persons with Disabilities (SCPD) was a success. She believes there were a lot of good recommendations specific to education that Council will want to review at our Fall Planning Retreat. From the Oral Health Coalition meetings, there is a Delaware Oral Health Coalition Calendar being produced that will share oral health information. The DDC is hosting parent workshops on inclusion. Information will be sent out as it becomes available. Wendy announced that the Supported Decision Making legislation was being heard in committee on April 20, 2016. Wendy shared that the legislation for unified sports is being pulled, but shared that the program is really expanding. Finally Wendy advised Committee chairs and co-chairs that final submissions for the annual report are due in July.

COMMITTEE REPORTS

ADULT TRANSITION SERVICES

Cathy Cowin reported that Dr. Dean Betts from DOE spoke to the group about drivers' education. Dr. Betts specifically addressed a list of questions from educators provided by Cathy. The group also discussed House Bill No. 184.

CHILDREN AND YOUTH

Karen Eller shared that Dr. Dan Rich of the Wilmington Education Advisory Committee held a question and answer session with the group regarding the action agenda for strengthening Wilmington education.

INFANT AND EARLY CHILDHOOD

Jennifer Pulcinella shared that the committee met with Matt Korobkin of DOE to discuss their proposed plan on how to provide appropriate services to three year olds in preschool.

POLICY AND LAW

Brian Hartman reported for the Policy and Law committee. The committee recommended taking action as recommended in the Policy and Law memo on items 3-13.

The commentary from the legal memo is as follows:

3. DOE Proposed Skilled and Technical Sciences Teacher Reg. [19 DE Reg. 882 (4/1/16)]

The Department of Education proposes to amend its qualification standards for a "skilled and technical sciences teacher".

The current regulation (§4.0) generally imposes the following qualification standards:

1) nine career-related credits in area of certification and six technical education pedagogy credits; AND

2) either a Bachelor's Degree in any content area or Associate's Degree plus 21 specified credits or two years of college or technical training plus 15 specified credits; AND

3) six years of work experience or teaching in the career area, two of which must be in the last five years; AND

4) if occupation requires a State license or certification, a valid and current Delaware license.

The current regulation allows an applicant to substitute an Associate's degree for one year of work experience and a Bachelor's degree for two years of work experience. The DOE proposes to double these standards to "2" and "4" years respectively:

> "Work Experience" means full time employment or work training experience in the specific Skilled and Technical Sciences career area of certification. An educator may substitute an Associate's degree in the specific Skilled and Technical Sciences career area for a maximum of ~~one~~ two years of work experience or a Bachelor's degree in the specific Skilled and Technical Sciences career area of certification for a maximum of ~~two~~ four years of work experience.

The effect of the change is to dilute the qualifications of the Skilled and Technical Sciences Teacher. For example, the current standards would authorize certification if an applicant with a Bachelor's degree has four years of work experience. Under the new standards, an applicant would be certified with a Bachelor's degree and two years of work experience. Since the DOE offers no rationale for the proposed change, it is difficult to assess justification for the dilution in standards. Perhaps the Department views this dilution of qualifications as justified given a shortage of candidates who meet the current standard. Given the lack of a disability nexus, and lack of a rationale for the amendment, the Council may wish to share these observations while taking no position on the proposed regulation.

4. DMMA Proposed Long Term Care (LTC) Facility Personal Needs Allowance Reg. [19 DE Reg. 893 (4/1/16)]

The Division of Medicaid and Medical Assistance proposes to raise the personal needs allowance for Medicaid-funded individuals residing in long-term care facilities.

Under Centers for Medicare and Medicaid Services (CMS) regulations, Medicaid-funded individuals residing in long-term care facilities are generally required to contribute to costs of institutional services after deducting certain allowable amounts. At 894, quoting 42 CFR §435.725. One deduction is a "personal needs allowance (PNA)" which, for "aged, blind, or disabled "persons must be at least $30/month for individuals and $60/month for couples. Id. The purpose of the PNA is to provide an "allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution".

The current PNA established by DMMA is $44/month for individuals and $88/month for couples. These amounts have not changed in 14 years, i.e., since 2002. At 894. The Division proposes to increase the PNA from $44/month to $50/month for individuals and from $88/month to $100/month for couples. The change would be effective July 1, 2016. The change is "subsidized" by federal funds. For example, in FFY17, the projected fiscal impact of the change is $71,596 in federal funds and $60,500 in State funds. At 895.

The committee discussed the following observations.

First, DMMA could consider a larger increase in the PNA. Consistent with the attachment, $44 in 2002 equates to $57.99 in 2016 based on inflation. Adopting a $50 rate reflects an increase of less than half the inflation rate. Moreover, since the State infrequently changes the rate, adopting an overly restrained benchmark in 2016 which will remain in effect for many years will accentuate the disparity. DMMA could consider adopting a $58 rate for individuals and a $116 rate for couples which would fully account for the inflation rate. This would ostensibly raise the State fiscal impact from $60,500 to $141,167 while increasing the federal contribution from $71,596 to

$167,057.

Second, on p. 896, DMMA may wish to consider substituting Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for Intermediate Care Facility for persons with Mental Retardation (ICF/MR) at 19 DE Reg. 888, 889 and 892.

Third, on p. 897, the following reference should be reconsidered in consultation with DDDS:

> If the recipient regularly attends a rehab/educational program off the grounds of his ~~nursing~~ or her long-term care facility, including employment for the purpose of rehabilitation in a sheltered workshop ~~off the grounds of the facility~~, $50.00 per month ~~(rather than $44)~~ will be protected; ...

The reference is somewhat archaic given Title 19 Del.C. §§740-747 (Employment First Act) and could be interpreted as excluding PNA eligibility to participants in supported employment as well as day habilitation programs. It may violate public policy to limit PNA to participants (including group home and foster home residents) in sheltered workshops to the exclusion of participants in supported employment.

Fourth, on p. 897, there are two references to an SGA (Substantial Gainful Activity) limit of $700. That was the SGA limit in 1999-2000. There is also an incorrect reference to "Department of Social Services (DSS)" rather than Department of Health & Social Services and references to "DSS" that ostensibly should be "DMMA".

Fifth, on p. 897, the reference to "unimpaired people" should be reconsidered. See Title 29 Del.C. §608.

The Council may wish to share these observations with DMMA, DDDS, the Employment First Commission and AARP. The Council may also wish to share at least the first observation with the co-chairs of the JFC.

5. DMMA Proposed Drug Rebate Agreement Regulation [19 DE Reg. 884 (4/1/16)]

The Division of Medicaid & Medical Assistance (DMMA) proposes to amend its Medicaid State Plan in the context of its drug rebate agreement.

As background, drug manufacturers are required to offer rebates on drugs used in the Medicaid program. States may enter into separate or supplemental drug rebate agreements as long as they achieve drug rebates equal to or greater than the drug rebates contained in a national HHS rebate agreement. At 885. Delaware currently participates in a multi-state purchasing pool ("TOP$")

which generates rebates. However, DMMA proposes to discontinue participation in "TOP$" and enroll in the "SSDC" pool based on the following rationale:

> The administration of the TOP$ Medicaid multi-state purchasing pool has (since) changed. This change has caused costs to increase, and made DMMA's ability to administer the drug rebate program more difficult. The Sovereign State Drug Consortium (SSDC) Medicaid multi-state purchasing pool provides states with more options and control when negotiating supplemental rebate rates, and allows for easier administration of the drug rebate program.

At 885. Enrollment in the new pool would be effective July 1, 2016. There would be no direct impact on Medicaid beneficiaries:

> The agency's proposal involves no change in the definition of those eligible to receive pharmaceutical services, and the Medicaid prescribed drugs benefit available to eligible recipients remains the same. In addition, the agency's proposal involves no change to providers' current practices.

At 886.

The committee did not identify any concerns with the proposed Medicaid State Plan amendment. Since the switch to a new pool is expected to provide increased flexibility and easier administration of the drug rebate program, the Council may wish to consider endorsement.

6. DMMA Proposed Medicaid LTC "Bed Hold" Payment Regulation [19 DE Reg. 888 (4/1/16)]

The Division of Medicaid & Medical Assistance proposes to amend its Medicaid "bed hold" standards applicable to long-term care facilities.

As background, a CMS regulation (42 CFR §447.40) allows states, at state option, to make "bed hold" payments to a long-term care facility during a resident's temporary absence due to hospitalization or other specified reasons. At 889. DMMA currently implements this option but plans to modify it for residents of an ICF/IID. In a nutshell, the normal paid seven-day bed-hold period per hospitalization would be extended to 14 days for Delaware's only ICF/IIDs - Stockley Center and Mary Campbell Center. The expected fiscal impact for FFY17 is $25,000 in State funds and $29,585 in federal funds. At 890-891.

The committee discussed the following observations.

First, on p. 889, the reference to 42 CFR §440.40 is incorrect. The reference should be to 42 CFR §447.40.

Second, consistent with 42 CFR §447.40, DMMA reaffirms the current policy of allowing up to 18 days per calendar year of "bed-hold" payments if included in the resident's plan of care. At 891. It would be informative to include the following clarifying sentence after Par. "2" on p. 891: "This may include absences included in a plan of care due to transfers to a 'specialized treatment facility' consistent with Title 16 Del.C. §1121(18)." This would be instructive to providers and residents seeking to reconcile Medicaid payment standards and the overlapping State "bed -hold" statute. For similar reasons, the same sentence could be added to §20650.2.1 on p. 892.

Third, waiver of the 18 day paid leave of absence limit can be obtained if the LTC facility applies and its medical director confirms medical necessity. This may be unduly limiting. It would be preferable to allow either the LTC facility or the resident [supported by his personal attending physician [16 Del.C. §1121(21)] to apply for a waiver since a resident's view may be different than the facility's view. CMS recognizes the divergence of interest in the context of transfers and discharges. See 42 C.F.R. §483.12(a)(3)(i); CMS Surveyor Guidance F201-203; and CMS proposed regulations, 80 Fed Reg. 42247-42249, 42254-42255. For example, the facility may prefer that the resident or resident's family "private pay" for the period in excess of 18 days since that results in higher payment.

The Council may wish to consider endorsement of the extended paid "bed-hold" period for ICF/IIDs while also sharing the above observations with DMMA, DDDS, and AARP.

7. DMMA Proposed Medicaid Autism Spectrum Disorder Services Reg. [19 DE Reg. 898 (4/1/16)]

The Division of Medicaid & Medical Assistance proposes to amend the Medicaid State Plan to address coverage and reimbursement of treatment services for beneficiaries up to age 21 with a diagnosis of autism spectrum disorder ("ASD").

As background, CMS issued the July 7, 2014 guidance outlining approaches to provide Medicaid services to eligible individuals with ASD. CMS noted that services often "fit" under the following categories: 1) other licensed practitioner services; 2) preventive services; 3) therapy services; 4) waivers; and 5) Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. See also related articles. DMMA is now implementing the guidance by adopting conforming Medicaid State Plan amendments.

The committee discussed the following observations.

First, there is some "tension" between the proposed requirement that a Medicaid beneficiary be "under 21 years of age" to qualify for "autism spectrum disorder treatment services" (p. 900) and special education eligibility extending to the end of the school year in which a student turns 21. See Title 14 Del.C. §3101(1). The age standard is ostensibly based on the EPSDT age limit but EPSDT should not be the sole eligibility basis for autism-related services. Moreover, "other licensed practitioner services", "preventive services", and "therapy services" are not limited to individuals under age 21.

Second, ASD services are barred if an individual is not "medically stable" At 900. Therefore, individuals with the most severe medical needs are anomalously ineligible for services. For example, query whether a beneficiary would be unable to obtain occupational or physical therapy services to remediate an "unstable" medical condition (e.g. helmet or assistive technology to address head banging or SIBS). Conceptually, the autism treatment services may be necessary to achieve medical stability.

Third, ASD services are barred if an individual qualifies for ICF/IID placement. At 900. This would ostensibly exclude anyone enrolled in the DDDS waiver (in which eligibility begins at age 12) which categorically requires that participants meet an ICF/IID level of care.

Fourth, the projected fiscal impact of the regulation is high, i.e., $1,223,105 in State funds in FFY17. At 901. Since the identified services (other licensed practitioner services; preventative services; therapy) are already covered by the State Plan, it's unclear why the projected fiscal impact is so high. Moreover, since private insurers must cover treatment of autism spectrum disorders (S.B. No. 22 from 146th General Assembly), private insurance should cover most services if an individual has both Medicaid and private health insurance.

Fifth, an individual cannot obtain a functional behavioral assessment, a behavioral support plan, or any ASD treatment services until a licensed medical professional under Delaware State regulation completes an evaluation. This categorical requirement appears unduly strict if an individual with an ASD diagnosis for years, perhaps based on an out-of-state evaluation, desires a behavioral support plan or ASD services.

Sixth, there is some "tension" between the following requirements:

> These evaluations may not be performed by the same professional who delivers or supervises the beneficiary's direct ASD treatment.

Attachment 3.1-A, Page 6 Addendum 1b (describing neurodevelopmental review by psychologists

and psychiatrists).

The provider who develops the behavioral plan of care should be the same provider who performed the behavioral assessment, except in extenuating circumstances...

As a practical matter, it may be impractical and counterproductive to exclude an evaluator from also providing services. This is not the standard model within the Delaware Medicaid program. For example, a speech therapist (ST), occupational therapist (OT), or physical therapist (PT) often performs an assessment of need, develops a treatment plan and provides therapy pursuant to the plan.

Seventh, the sources of information for the functional behavioral assessment includes everyone but the individual with the ASD diagnosis. It would be preferable to include the individual in the list which otherwise includes schools, family, pediatricians, etc.

Eighth, DMMA may wish to amend the following provision in Attachment 3.1-A, Page 6, Addendum 1d by adding the underlined language: "(6) The use of Behavior Modifying Medications without a formal assessment and diagnosis of a corresponding mental health disorder by physician <u>or advance practice registered nurse</u> ." <u>See</u> 24 <u>Del.C</u>. §1902.

Ninth, in Attachment 3.1-A, Page 6 Addendum 1e, Par (12), DMMA may wish to substitute "individual" for "child".

Tenth, the following requirement is highly objectionable:

> (e) Presence/Availability of Caregiver. In order to ensure that the services are covered under the preventive services benefit category and do not include non-coverable services such as child care, respite, or related services, as well as to ensure the clinical success of the services, a caregiver must be present and/or available in the setting where services are being provided at all times (even when not directly participating in the services) in order to care for individuals under the age of eighteen.

This is a discriminatory requirement which "stereotypes" all individuals under 18 with an ASD diagnosis as requiring 24/7 care under constant adult supervision. It is not required that parents of minors with other conditions be physically present on-site when a minor receives Medicaid services. There are 17 year old individuals with Asperger's who could drive themselves to an appointment and have absolutely no need for parental accompaniment. Moreover, the statement that "respite" is categorically a "non-coverable" service is incorrect. It is a covered service under the Diamond State Health Plan Plus (DSHP+) program and may be available under the EPSDT benefit.

Eleventh, the following utilization limit is highly objectionable:

> (f) Limitations on ASD Treatment Services: Total ASD treatment services from all sources may only be the amount medically necessary for each individual, up to 25 hour (sic "hours") per week, which may be exceeded with prior authorization based on medical necessity.

A. This limitation is at odds with the EPSDT expectation that covered individuals will receive all Medicaid services needed to ameliorate conditions identified through screening and assessment.

> The goal of this benefit is to ensure that children under the age of 21 who are enrolled in Medicaid receive age-appropriate screening, preventive services, and treatment services that are medically necessary to correct or ameliorate any identified conditions - the right care to the right child at the right time in the right setting. This broad scope supports a comprehensive, high-quality health benefit.

At 3.

NHeLP characterizes attempts to place hard caps on ASD services as illegal under EPSDT:

> Another common problem is that some states place hard limits on the hours of service Medicaid will provide in a week or a month. These limits, which are illegal under EPSDT, prevent children with the highest need from getting all the medically necessary care to which they are entitled. (See CMS, EPDST Coverage Guide at 23).

NHeLP, "Autism Spectrum Disorders", Health Advocate (October, 2015) at 3.

The CMS EPSDT Guide is corroborative:

> Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements. ...For example, while a state may place in its State Plan a limit of a certain number of physical therapy visits per year for individuals age 21 and older, such a "hard" limit could not be applied to children.

Although CMS suggests some leeway with "soft" limits incorporated into medical necessity standards, DMMA is not amending its medical necessity regulation. Rather, it is manifestly

imposing a cap based on budgetary considerations.

B. There is no comparable cap on ST, OT, or PT, preventive services, and other licensed practitioner services in the Medicaid State Plan generally so imposing a cap simply because a beneficiary has an ASD diagnosis is ostensibly impermissible discrimination under the ADA and Section 1557 of the ACA. See attachment.

The Council may wish to consider sharing these observations with DMMA and autism advocacy organizations. The Council may also wish to consider sharing the observations with CMS.

8. Senate Bill No. 214 (Employment Discrimination)

This legislation was introduced on March 24, 2016. As of April 11, it awaited action by the Senate Labor & Industrial Relations Committee.

As background, Delaware law currently imposes a 120-day statute of limitation for the filing of an employment discrimination complaint. This includes complaints based on the "Persons with Disabilities Employment Protections Act". See Title 19 Del.C. §§712 and 727. The 120-day standard does not conform to federal law. Consistent with the excerpt from the Equal Employment Opportunity Commission (EEOC) Website, the statute of limitation is 300 days for states whose departments of labor are authorized to process complaints:

> IX. What Agency Handles a Charge that is also covered by State or Local Law?
>
> Many states and localities have anti-discrimination laws and agencies responsible for enforcing those laws. EEOC refers to these agencies as "Fair Employment Practices Agencies (FEPAs)". Through the use of "work sharing agreements", EEOC and the FEPAs avoid duplication of effort while at the same time ensuring that a charging party's rights are protected under both federal and state law.
>
> VIII. What Are the Time Limits for Filing a Charge of Discrimination?
>
> ...There are strict time limits within which charges must be filed:
>
> - A charge must be filed with EEOC within 180 days from the date of the alleged violation, in order to protect the charging party's rights.
>
> - This 180-day filing deadline is extended to 300 days if the charge is also covered by state or local anti-discrimination law.

[emphasis supplied]

Senate Bill No. 214 conforms the State statute of limitations to match the above federal standard, i.e., 300 days. This is highly preferable for multiple reasons. First, individuals looking at the current Delaware Code may be misled into believing they only have 120 days to file a charge under both federal and state law. Second, it facilitates the administration of the State Department of Labor to have a State charge time line equal to the federal standard. Under current law, Delawareans who file charges within 120 days can have their claims processed by the State while those filing between 121-300 days have their claims routed to the federal EEOC for processing. See excerpt from Delaware DOL Website. This is an awkward and confusing system for consumers.

For the reasons above, the Council may wish to consider endorsement.

9. House Bill No. 211 (Youth Shackling)

This legislation was introduced on March 17, 2016. As of April 11, it had been approved by the House Judiciary Committee but awaited action by the House Appropriations Committee.

In a nutshell, the bill would bar the automatic use of restraints (e.g. handcuffs; chains; straitjackets) for juveniles appearing in Family Court delinquency proceedings. The Court could authorize use of restraints only on a case-by-case basis justified by findings that restraints are necessary and there are no less restrictive alternatives (lines 32 - 48). The preamble to the bill, as well as the three articles reviewed by the committee, underscore the reasons why shackling of juveniles should be limited. It undermines the presumption of innocence, is demeaning and traumatizing, and deters dialog. Since minorities are statistically more likely to be placed in juvenile detention facilities, the use of shackles is disproportionately applied to minorities. According to the January 23 article, 71.8% of juveniles admitted to detention facilities in Delaware are minorities - "making it seven time more likely that African-American youth will be placed in a state detention center than white youth."

According to the January 23, 2016 article, "twenty-three states have banned the practice of juvenile shacking by legislation or court order" and "about half of those have done so since 2014." Many prominent organizations are supporting a national initiative to ban or reduce the use of restraints in delinquency proceedings (lines11-20). For example, the American Academy of Child & Adolescent Psychiatry issued a policy statement characterizing the routine shackling of juveniles as "demeaning, humiliating, and stigmatizing" and contributing to trauma (lines 14-16).

The bill is accompanied by the $232,996.24 fiscal note. It envisions the hiring of four Youth Rehabilitative Services (YRS) counselors to "enable two YRS staff members to be present with each youth in a court room."

Given the compelling justification for the legislation, the Councils may wish to consider endorsement. The Council may wish to share commentary with the Public Defender and ACLU.

10. Senate Bill No. 221 (Employer Tax Credit: DVR & DVI Referrals)

This legislation was introduced on March 24, 2016. As of April 11, it awaited action by the Senate Finance Committee.

As background, only 34.5% of non-institutionalized Americans ages 21-64 with a disability are employed. The Delaware statistic is similar, i.e., only 36.1% of such adults with a disability are employed. Delaware has several laws which promote the hiring of individuals with disabilities (lines 5-6 and 16 Del.C. §5503). In the past few years, multiple programs have been initiated to "jump-start" training and employment opportunities for this constituency. Such initiatives include the DHSS Pathways to Employment program and the PROMISE program. See summaries. These programs are helpful but may be limited to certain age groups and disabilities. For example, individuals with traumatic brain injury, the "signature" injury of the Iraq and Afghanistan conflicts, do not qualify for either program.

Federal tax incentives exist to promote hiring of individuals with disabilities. Many states, including Maryland and New York, offer a State tax credit to supplement the federal incentives. See articles.

Senate Bill No. 221 is similar to proposed legislation shared by the Councils with the JFC in February, 2013. Senate Bill No. 221 authorizes a State tax credit for employers who hire referrals from the Division of Vocational Rehabilitation or the Division for the Visually Impaired after January 1, 2017. The amount of the credit would be equal to 10%, but in no event greater than $1,500, of the gross wages paid to a qualifying person. The credit would be available for the year in which the employee is hired and the 2 taxable years thereafter (lines 28-38).

One advantage to linking the credit to DVR referrals is that DVR is not limited to only certain disabilities. DVR serves individuals with a wide range of physical and mental impairments, including traumatic brain injury. It focuses on individuals with "most significant" and "significant" disabilities. Consistent with the attached excerpt from 2015 Annual Report from DVR's Rehabilitation Council, in FY15 it served 7,757 clients of whom 2,861 were new applicants. It achieved a successful employment outcome for 1,138 clients with an average hourly wage of approximately $10.50/hour. The availability of a State tax credit should bolster DVR's prospects for securing successful employment outcomes since hiring DVR referrals will be more attractive to employers.

Since the employment rate for Delawareans with disabilities is very low (36.1%), and this legislation would encourage the hiring of individuals with disabilities, the Councils may wish to

consider endorsement.

11. <u>Senate Bill No. 186 (Disabled Veteran School Tax Refund Fund)</u>

This legislation was introduced on January 28, 2016. As of April 11, it awaited action by the Senate Finance Committee.

The bill (lines 39-42) would establish a fund of $3,000,000 to cover the cost of maximum school tax refunds as follows:

- $200 for qualified veteran with a V.A. disability rating of 10% to 20%;
- $350 for qualified veteran with a V.A. disability rating of 30% to 50%;
- $500 for a qualified veteran with a V.A. disability rating of 60% or higher.

A qualified veteran would have to be legally domiciled in the State and the credit would only apply to the veteran's principal residence (lines 32-38). Consistent with the attached fiscal note, the legislation is expected to benefit approximately 4,346 veteran homeowners in Delaware. Likewise, the fiscal note anticipates that the average refund under the bill would be $368.

The committee discussed the following observations.

First, the reference to "disabled veteran" does not reflect "people-first" language and is ostensibly disfavored under Title 29 <u>Del.C</u>. §608.

Second, at first glance, the references in lines 40-42 appeared "underinclusive" since they omitted disability ratings between 21-29% and 51%- 59%. However, consistent with an article reviewed by the committee, the V.A. system only uses 10% increments in its disability rating system so the references are accurate.

Third, if claims exceed the amount in the "Disabled Veteran School Tax Refund Fund", the "shortfall" may be derived from "the general contingency appropriation in the Department of Education" (lines 8-9). Since the fiscal note only contemplates an annual cost of $1.6 million of the $3.0 million fund, there may not be a shortfall in the near future. However, this feature of the legislation may be of some concern to public educational interests.

Fourth, New Castle County already reduces the assessed value of homes owned by qualifying persons with disabilities. Consistent with the NCC summary, qualifying individuals are eligible for the following subsidy:

> School Tax - They receive a reduction in their assessed value of up to $32,000. For loss of limbs or loss of limbs requiring home to be equipped with special fixtures, an additional $42,000 may be added to a maximum of $74,000. ... If the disability is Armed Forces Related, the taxpayer may receive an additional reduction of $5,000 off the assessed value of the residence for both County and School Taxes.

Thus, a veteran with a service-connected disability in New Castle County would ostensibly benefit from both a reduced "countable" assessment and the school tax refund authorized by this legislation.

Since the legislation would benefit veterans with disabilities and prioritize a higher refund based on extent of service-connected disability, the Council may wish to consider endorsement.

12. <u>House Bill No. 268 (Substance Exposed Infants & Medically Fragile Children)</u>

This legislation was introduced on March 3, 2016. As of April 11, it awaited action by the House Judiciary Committee.

In a nutshell, approximately 3% of babies born in Delaware qualify for a diagnosis of neonatal abstinence syndrome (NAS) in which the infant undergoes opiate withdrawal. That percentage has been growing in recent years. The Division of Family Services (DFS) substantiates abuse in approximately 10% (44/448) of cases of suspected neglect or abuse reported to it among babies born with drugs or alcohol in their system. Medical professionals prefer to place pregnant women with addictions on methadone resulting in only short-term effects on babies treated for withdrawal upon birth.

House Bill No. 268 (lines 63-64) would require health care providers to report substance exposed infants not more than four weeks of age (line 51) to the Division of Services for Children, Youth and their Families (DSCY&F). Such reports would be entered into the child protection registry on the same basis as reports of abuse or neglect (lines 79-81). Although reports of abuse or neglect can be made anonymously, this is not permitted for reports of substance exposed infants (lines 82-84). A "plan of safe care" would be developed for cases accepted by DFS for investigation or family assessment (lines 16-19 and 110-111). Apart from substance exposed infants, the bill would also require development of a plan of care for cases accepted for investigation or family assessment involving any "medically fragile child" (lines 126-127) of any age (lines 42-44).

The committee discussed the following observations.

First, the legislation reinforces an autocratic model in which the State imposes requirements and offers little help to new mothers with substance abuse profiles. The bill (lines 45-50) contemplates unilateral development of the "plan of safe care" with zero input from the parent. This "top-down" plan is then shared with agencies but not the parent (lines 47-49). This "Kafkaesque" approach is not a collaborative model which "engages" the new mother in a joint venture to benefit her infant.

Second, the articles describe successful outcomes for parents receiving wrap-around services while

highlighting the paucity of resources available to many parents:

> Holly Rybinski, of Newport, said she had to go to jail in order to get the drug treatment she needed. That was almost two years ago. She had stayed clean for five years, but while she was pregnant with his child, her partner overdosed and died. Consumed with grief, Rybinski turned to heroin and cocaine during the last five months of her pregnancy. After she gave birth to the son James April 8, 2014, at Christiana Care's Wilmington Hospital, she was ready to be clean. She said the Division of Family Services told her that they had to take custody of him since James tested positive for drugs, she wasn't in a treatment program and Rybinski had a record. They told her she had 90 days to find employment, treatment and stable housing and then they could discuss putting him back in her care. That request was easier said than done. ..."I tried five different times to get into treatment," Rybinski said. "It was one obstacle after the other." As the number of pregnant and addicted mothers grows, the need for treatment is even more critical. Community members, families and those now in recovery, like Rybinski, have long lamented Delaware's lack of residential treatment options. Many people have to wait days and even weeks to get a bed. ...Currently, there is one state-run treatment program for expectant or new mothers recovering from addiction in Delaware, but it is only for women who are incarcerated and it is in Newark. ...Brandywine Counseling ran a program for expecting moms wrestling with addiction, called Lighthouse, downstate in Ellendale, but is closed in September due to budget cuts and staffing shortages. ...(I)t was extremely successful. Nearly 100 percent of women were able to give birth to babies free of drugs.

Third, the bill envisions development of the same autocratic "plan of safe care" for any parent of a "medically fragile child" of any age if the parent is "unable" to "provide or ensure necessary care" (lines 42-44 and 126-127). The definition of "medically fragile child" is extremely broad, i.e., essentially covering any child at risk of a condition that requires services of a type or amount beyond that of an average child (lines 42-44). The implication is that parents of a child with a disability are at fault, culpable if they cannot guarantee ("ensure") necessary care, and subject to the same "plan of safety care" as parents delivering addicted babies. This is reminiscent of the 1960s view of autism as caused by "frigid" mothers - stereotyping parents of children with disabilities as 'at fault" for their child's medical condition.

Fourth, the central plan of care for medically fragile infants and toddlers is the collaborative family support plan developed under Title 16 Del.C. §§214 and 215. It is counterproductive to supplant the family support plan with a "plan of safe care" administered by a child neglect/prevention agency.

The Council may wish to consider the following recommendations:

1. The "medically fragile child" references (lines 42-44 and 126-127) should be deleted.

2. The "plan of care" provisions (lines 45-50) should be amended as follows:

    a. Ensure parental input and collaboration in development of the plan; and

b. Ensure that the plan includes support services rather than simply directives or benchmarks for parents to achieve on their own. For example, consider the following amendment:

> The plan of care shall identify all material impediments to family preservation and the itemized, available resources specifically offered to the parent to overcome each impediment including, if relevant:
>
> a. mental health treatment;
> b. substance abuse treatment;
> c. safe housing; and
> d. any public assistance program operated or administered by a State agency.

3. The State should expand resources and programs available to expectant mothers with addictions and mothers of substance exposed infants.

The Council may wish to share commentary with other disability advocacy agencies, the Attorney General, and the Public Defender.

13. House Bill No. 214 (Nurse Workplace Violence Protection)

This legislation was introduced on June 30, 2015. On March, 23, 2016, it was released from the House Public Safety and Homeland Security Committee. As of April 11, it awaited action by the House.

The committee discussed the following observations.

Under current law, if a person intentionally causes "physical injury" to a member of the general public, the crime is a misdemeanor A punishable by up to one year in prison. There is special statute [11 Del.C. § 612] which elevates the misdemeanor to a felony D if a person intentionally causes "physical injury" to a nurse "while [the nurse] is rendering emergency care". The penalty for a class D felony is up to eight years in prison. The definition of "physical injury" is "impairment of physical condition or substantial pain". Therefore, the current law elevates the maximum one year prison term to a maximum eight year term for an assault on a nurse providing emergency care with no significant injury apart from "pain". House Bill No. 214 would expand the application of the eight-year prison term to nurses in non-emergency contexts, i.e., while "performing a work-related duty" (lines 17-18). While well intentioned, the concern is that authorizing a prison term not double, triple, or quadruple but eight times in length for an assault resulting only in some pain seems disproportionate to the offense. One compromise would be to elevate the offense against a nurse to a felony F or G which carry two and three year prison terms respectively.

Authorizing excessive prison term runs counter to recent, high-publicized legislative initiatives to deter sentences disproportionate to the offense

Policymakers may wish to consider unintended consequences. The bill could easily result in prosecution of patients with compromised capacity at the time of the alleged crime. For example, individuals with urinary tract infections may display symptoms akin to mental illness. Individuals with an intense fear of needles may defensively strike out at a nurse attempting to perform an injection. An elderly patient may strike out defensively at a nurse attempting to impose wrist or mechanical restraints on the patient to prevent the patient from removing tubes or aggravating wounds. Medications or a high fever may compromise executive functioning and self-control. A patient who does not speak English may defensively try to block an injection or push a nurse away out of a lack of understanding. A patient may experience involuntary movements or seizures which a nurse could misinterpret as voluntary acts of aggression. A patient with an undiagnosed TBI may strike out as a function of brain injury. The "unintended consequence" of the bill may be to unnecessarily "criminalize" a large number of vulnerable patients.

Finally, we are dubious that there would be any practical deterrent effect if the legislation were enacted. It is unlikely that aggressive or disoriented patients will deliberate and gauge their behavior based on whether an assault is a misdemeanor versus a felony under the Delaware Code.

In conclusion, while well intentioned, the legislation ostensibly authorizes a penalty disproportionate to the offense and may unnecessarily "criminalize" a large number of vulnerable patients.

The Council may wish to share these observations with policymakers, including the Attorney General, Public Defender, and ACLU.

MEMBERSHIP COMMITTEE

There was no report at this time.

PERSONNEL COMMITTEE

There was no report at this time.

OUTSIDE COMMITTEE UPDATES

There were no outside committee reports at this time.

CHAIR REPORT

Robert announced absent members as well as guests in attendance. Robert also announced that letters and responses are available for viewing at the back of the room.

A **motion** was made and **approved** to adjourn the meeting**.**