

MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory and Policy Initiatives

Date: November 8, 2010

I am providing my analysis of fourteen (14) regulatory and policy initiatives in anticipation of the November 18 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. DOE Final Gifted Kindergarten Early Admission Regulation [14 DE Reg. 459 (11/1/10)]

The GACEC commented on the original version of this regulation in May, 2010. The Council identified a combination of six (6) technical and substantive problems with the proposal. The most significant observation was that sole reliance on cognitive aptitude testing was at odds with the broad statutory authorization of considering the student's "best interests" and characteristics apart from aptitude (e.g. visual and performing arts ability; psychomotor ability).

The DOE considered the comments and reviewed the merits of the entire regulation. It then issued a new proposed regulation in September repealing the regulation in its entirety in deference to the broader statutory standards. The SCPD and GACEC endorsed that approach.

The Department has now issued a final regulation which acknowledges the endorsements and repeals the regulation.

I recommend no further action.

2. DSAMH Final Substance Abuse Facility Licensing Regulation [14 DE Reg. 471 (11/1/10)]

The SCPD and GACEC submitted thirty-six (36) comments on the proposed version of this regulation in July, 2010. The Division of Substance Abuse & Mental Health is now adopting a final regulation incorporating some amendments prompted by the commentary. The regulation lists each of the 36 comments and DSAMH's responses at pp. 472- 477. Given the length of the itemized comments and responses, I am not reproducing them in this memo. Overall, the Division effected amendments in response to comments 1, 2, 4, 9, 10, 12, 13, 14, 18, 19, 20, 32, and 35. The Division issued a curious response to comments 21, 22, 24, 25, 26, 27, and 30. DSAMH indicates that it is unable to comment on each suggestion in these seven (7) comments because "the standard referred to does not exist". I am attaching a PDF version of the 8 pages at which the standard referred to does exist. The Council may wish to informally share the pages with DSAMH. All of the 7 seven comments involved simple typographical or grammatical errors. The Administrative Procedures Act authorizes agencies to informally correct typographical and technical errors without publication. See Title 29 Del.C. §10113(b)4. Correction of typographical and grammatical errors obviates misinterpretation of standards and promotes compliance.

3. DMMA Final Consolidation of E&D, ABI, & Asst. Living Waivers [14 DE Reg. 461 (11/1/10)]

The SCPD submitted comments on the May 19, 2010 pre-publication draft of the Department's consolidated waiver application. DHSS responded with an itemized July 29 response. DHSS then published its waiver application as a proposed regulation in August [14 DE Reg. 88 (August 1, 2010)]. The SCPD submitted the attached 10-page memo which reiterated its original comments on the May 19 draft followed by DSAAPD's response. The SCPD also included supplemental responses to Comments 3, 4, 5, 9, 10, 11, 16, 18, 19, 22, 23, 24, 25, 27, and 28. The Department has now issued a final regulation which includes the original SCPD commentary, July DHSS response, August 16 SCPD supplemental commentary, and DHSS response to the supplemental commentary. I will only address the supplemental commentary and responses.

3. Comment: The Council expressed concern that DSAAPD case managers may lack specific training and expertise to address needs of individuals with ABI. The Council also recommended consumer education on availability of in-home respite as a personal care service.

Response: DHSS has identified 4 case managers and a planner to be formally trained as Certified Brain Injury Specialists. DHSS will be proactive in informing beneficiaries about respite and personal care.

4. Comment: The Council recommended consideration of use of the client satisfaction surveys used by JEVS and Easter Seal for PAS participants.

Response: DHSS has questionnaires designed to address federal HCBS waiver quality indicators.

5. Comment: SCPD questioned lack of check-off for “brain injury” subgroup.
Response: DHSS reiterated that, while not intuitive, lack of check-off is per CMS guidance.
9. Comment: The Council questioned the validity and reliability of use of standard “long term care assessment tool” to assess level of care for persons with ABI.
Response: Same tool is currently used for ABI waiver and is broad-based.
10. Comment: SCPD encourages inclusion of provision for supported and competitive employment or TBI Clubhouse as alternative to day-care type programs.
Response: DHSS is “open” to exploring options subject to funding availability.
11. Comment: The Council recommends adoption of reimbursement rates for adult habilitation sufficient to attract quality providers.
Response: Efforts are made to establish rates which are fair and appropriate.
16. Comment: The Council recommends inclusion of “advanced practice nurse” and “licensed professional counselors of mental health” in the current version of the waiver.
Response: Even such ostensibly minor amendments would involve making changes to budgets, provider enrollment materials, quality review strategies, and claims payment systems. DHSS is predisposed to address in future amendment.
18. Comment: The SCPD recommends incorporation of a requirement to maintain service plans beyond 3 years.
Response: The 3-year period is part of the CMS template.
19. Comment: The Council promoted adoption of a standard requiring more frequent agency-beneficiary contact.
Response: DHSS will research best practices in this context.
22. Comment: The Council recommends consideration of inclusion of CLASI in section on grievances, official events, and quality assurance.
Response: DHSS will assess ways that CLASI could be resource in identified contexts.
23. Comment: The Council recommends inclusion of additional references to Ombudsman in abuse/neglect context.
Response: DHSS will research as part of future amendment.

24. Comment: The Council questioned accuracy of statement that “the State does not permit or prohibits the use of restraints or seclusion.

Response: DHSS will research as part of future amendment.

25. Comment: The SCPD notes that “medication administration” section is underinclusive.

Response: DHSS notes that, although the provision is not literally limited to assisted living facilities, it would only apply to such facilities as practical matter.

27. Comment: The SCPD expressed interest in having input on personal care services authorization guidelines.

Response: DHSS will be in contact with the SCPD.

28. Comment: The Council recommends more frequent assessment of waiver implementation and disaggregation of data since subsets of beneficiaries (e.g. TBI survivors) could be dissatisfied with services while larger E&D participant group is satisfied.

Response: DHSS shares the SCPD’s interest in ensuring that the needs of persons with ABI are not overshadowed by aggregate data collection.

I recommend issuing a “thank-you” letter to DHSS for considering the Council’s comments.

4. DMMA Prop. Child Eligibility for GA and TANF Regulation [14 DE Reg. 357 (11/1/10)]

In August, 2010, the SCPD commented on a related proposed regulation switching eligible children from General Assistance (“GA”) to TANF. The Council noted the generally positive aspects of the proposal (e.g. increased cash benefit) but also identified some concerns. The Division of Medicaid & Medical Assistance adopted a final regulation in October with some amendments prompted by the Council’s commentary. [14 DE Reg. 304 (October 1, 2010)]

The Division is now issuing a second proposed regulation which is essentially a “housekeeping” measure which amends the Medicaid State Plan to eliminate child eligibility under GA. My only concern is that DMMA is repealing some regulations which apply to young adults, i.e., Section 15100, second sentence; Section 16120, third through fifth sentences. The TANF regulation treats individuals as adults upon turning 18. See §3027 at 14 DE Reg. 304, 312 (October 1, 2010). Hence, an 18-19 year old is not a “child” for purposes of qualifying for TANF. Therefore, it is counterintuitive to repeal GA standards which apply to 18-19 year olds since they may still qualify for GA.

I recommend sharing the above concern with the Division.

5. Delaware Council on Police Training Child Abuse Training Reg. [14 DE Reg. 342 (11/1/10)]

As a result of the highly publicized allegations of child abuse by Dr. Bradley, Widener Law School Dean Ammons agreed to develop a report with recommendations to reduce prospects for child abuse in Delaware. One of her recommendations in the resulting report was to enhance training of law enforcement personnel. Based on the recommendation, legislation (H.B. No. 457) was enacted which imposes the following obligation on the Delaware Council on Police Training:

Mandate training for all persons seeking permanent or seasonal appointment as a police officer in the detection, prosecution and prevention of child sexual and physical abuse, exploitation and domestic violence, and the obligations imposed by Delaware law, including section 903 of title 16, and federal law in the prompt reporting thereof.

The law was effective August 1, 2010.

The Delaware Council on Police Training is now issuing an emergency regulation to implement the statute. The regulation would have the following effects: 1) effective January 1, 2011, new applicants for certification will be required to complete 1.5 hours of relevant training; 2) currently certified officers will be required to complete 1.5 hours of relevant training by March 1, 2011; and 3) certified officers will thereafter be required to complete 1 hour of relevant training every 3 years.

I did not identify any significant concerns with the emergency regulation. I recommend endorsement subject to consideration of one technical amendment, i.e., the word “(a)nnual” in §5.3 should be deleted since some of the described training is not an annual requirement. The SCPD may wish to share a courtesy copy of its communication with the Victim Rights Task Force.

6. DMMA Prop. Public Assistance Reporting Information System [14 DE Reg. 360 (11/1/10)]

Consistent with the “Background” section in the regulation, federal law effective in 2009 requires states to sign an agreement to participate in a “Public Assistance Reporting Information System” (“PARIS”) as a precondition of receiving Medicaid funding for automated data systems. The PARIS system is operational in all 50 states to “maintain program integrity and detect or deter improper payments”. At 360. The attached June 21, 2010 CMS policy letter notes that PARIS has been operating since 1993. It permits states to identify cases in which persons are enrolled in Medicaid and other programs in more than one state. The CMS letter also recites that “PARIS may also be used as a tool to identify individuals who have not applied for Medicaid coverage, but who may be eligible based on their income.”

The text of the proposed DMMA regulation is based on the model attached to the CMS letter.

Since DMMA is already participating in PARIS, and the regulation is essentially required to qualify for federal funding for automated data systems, I recommend endorsement.

7. DMMA Proposed Citizenship & Alienage Regulation [14 DE Reg. 363 (11/1/10)]

In April, the SCPD endorsed (subject to one amendment) a DMMA regulation extending Medicaid and CHIP coverage to some classes of pregnant women and children based on a change in federal law. See attached April 26, 2010 SCPD memo. DMMA then adopted the regulation in June with the recommended amendment. [13 DE Reg. 1540 (June 1, 2010)] CMS subsequently issued guidance via the attached State Health Official Letter #10-006 (July 1, 2010). The guidance includes a model State Plan amendment. DMMA is now revising the regulation adopted in June to conform to the latest guidance. DMMA has also submitted a revised State Plan amendment to CMS based on the model. At 364.

Since the original regulation expanded health care coverage while diverting some beneficiaries from a State-funded program to federally-subsidized programs, and since the technical revisions are designed to conform to federal guidance, I recommend endorsement.

8. DMMA Prop. Medicaid & CHIP Quality Assurance Reg. [14 DE Reg. 361 (11/1/10)]

The Division of Medicaid & Medical Assistance proposes to adopt a “Delaware Medicaid and CHIP Managed Care Quality Strategy”. Since DMMA recites (p. 362) that the final version must be submitted to CMS no later than December 3, the SCPD may wish to share its comments promptly to facilitate timely revision. The document is eighty-four (84) pages in length.

I have the following observations.

First, on p. 3, Quality Strategy Overview, last paragraph, there is a reference to providing quality care ...“through increased address and appropriate and timely utilization of health care services. The word “address” is obviously erroneous.

Second, on p. 6, DMMA describes a QII Task Force which includes “representatives from all CHIP funded programs and waivers, MCO’s, Health Benefits Manager, Pharmacy Benefits Manager (PBM), the External Quality Review Organization (EQPO), State agencies receiving Medicaid and CHIP funding, and the MMDS leadership team.” DMMA may wish to consider whether the Task Force could be strengthened through addition of a representative from the SCPD, CLASI, or similar organization.

Third, on p. 8, the chart lists “Division of Child Mental Health Services”. The reference should be updated to “Division of Prevention and Behavioral Health Services”.

Fourth, p. 10 describes the MCOs under the Diamond State Health Plan. It omits the Division of Prevention and Behavioral Health Services which serves as an MCO under the Plan. This is a major concern with the entire document. There are simply no references to the Division. For example, performance data is only generated for Unison and DPCI. See pp. 65-67. The Plan should address quality assurance within the Division acting as an MCO.

Fifth, on p. 11, CHIP section, second paragraph, there is a reference to “infants (under age 1) under 200% covered through a Medicaid expansion program...” I believe the reference should be to “under 200% of the Federal Poverty Level (FPL)”.

Sixth, on p. 11, last paragraph, there is a reference to a 5 year bar on child eligibility if the child entered the United States after 8/22/96. I believe DMMA rescinded that bar earlier this year. See 13 DE Reg. 1540 (June 1, 2010).

Seventh, p. 17 recites that MCOs are required to develop a treatment plan for all beneficiaries qualifying as persons with special health care needs, including those with a “serious or chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally”. The Council may wish to ask if DMMA has a template for such plans or if each MCO has its own criteria. If DMMA does not have a template or standards, it could consider adopting them.

Eighth, on p. 22, it appears that information on “grievances” and “appeals” is reviewed. It is unclear if fair hearing results are included in this assessment. If not, DMMA may wish to include such review in assessing MCOs.

Ninth, p. 22 refers to an MCO requirement of ensuring the availability of a no-cost second opinion from a qualified health care professional. I have not seen this aspect of MCO coverage advertised. The Council may wish to ask DMMA if there are standards which define eligibility for a second opinion.

Tenth, p. 33 refers to the following MCO duty: “(s)atisfactory methods for ensuring their providers are in compliance with Title II of the Americans with Disabilities Act”. Title II covers public agencies. Title III covers private entities. It would be preferable to amend the reference to read “Titles II and III of the Americans with Disabilities Act”. Consistent with the attachments, the accessibility of health care provider offices and equipment (e.g. height adjustable examination tables) has historically been a barrier to effective health care, particularly for persons who must transfer from a wheelchair or use a restroom. The Council may wish to ask DMMA how it assesses MCO compliance with the mandate. Do MCOs survey their providers on accessibility, provision of interpreters for the Deaf, etc?

Eleventh, p. 35, Notice of Adverse Action section, contains the following sentence: “The MCO’s notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.” The attached 42 C.F.R. §438.404 does not contain an exemption from the written notice requirement for notices to providers. DMMA may wish to reassess the accuracy of the sentence.

Twelfth, on p. 40, Confidentiality section, second bullet, some words appear to have been omitted. The second “sentence” reads as follows: “And shall be afforded access within thirty (30) calendar days to all members’ medical records whether electronic or paper”.

Thirteenth, on p. 45, General Requirements section, last bullet, second “sentence”, some

words appear to have been omitted and the 59-word “sentence” is awkward and difficult to understand. The second “sentence” reads as follows: “And who if deciding an appeal of a denial that is based upon lack of medical necessity...disease.”

Fourteenth, on p. 40, Duration of Continued or Reinstated Benefits section, the reference to “within 10 days from when the MCO mails an adverse MCO decision” is not the correct timeframe. The federal regulation [42 C.F.R. 438.420(c)] and 16 DE Admin Code, Part 5000, §5303 clarify that the relevant period is “the period between the date a notice is mailed and the effective date of the action”. Thus, if an MCO provides 15 days notice prior to the effective date of an action, there are 15 days to request a hearing and maintain benefits. The reference could be amended to read “within the timely notice period between mailing of the notice and the effective date of the action”.

Fifteenth, p. 55 addresses oral interpreter services for foreign languages. It would be preferable to also include a reference in the document to interpreter services for the Deaf.

Sixteenth, the data on p. 67 suggest a significant disparity in mental health inpatient and outpatient services between DPCI and Unison. Moreover, pp. 68-69 contain the following recital:

The benchmark for Antidepressant medication management has not been met for either MCO. DPCI showed a decrease in compliance with effective acute phase treatment from 2008 (46.92 percent) to 2009 (45.58). Unison, on the other hand, made some progress toward the benchmark with an increase from 2008 (41.84) to 47.64 percent in 2009. Effective continuation phase treatment showed a slight decline for DPCI from 2008 (31.51 percent) to 28.05 percent in 3009 (sic “2009) while Unison stayed steady at 27.55 percent in 2008 and 27.95 percent in 2009.

The Council may wish to ask for more specifics on mental health treatment data since it appears that MCOs may be “falling short”. The Council may wish to share this concern with DSAMH and DPBHS as well.

9. DOE Prop. School Nurse Regulation [14 DE Reg. 354 (11/1/10)]

The Professional Standards Board proposes to adopt a revised school nurse certification standard. Certification is required for school nurses serving students in the public school system.

I have the following observations.

First, it is not clear if a nurse must be licensed by the Delaware Board of Nursing (as juxtaposed to holding an out-of-state license) to qualify for school nurse certification. Section 6.1.4 refers to “a valid nursing license” and Sections 4.1.2 and 5.1.1 refer to an RN license “recognized” by the Delaware Board of Nursing. The Nurse Practice statute ostensibly contemplates that nurses qualifying to practice based on an interstate compact would receive a Delaware license. See Title 14 Del.C. §1902(h). The DOE may wish to consult the Board of Nursing and incorporate more specific language in the regulation.

Second, in §6.1.4, the DOE may wish to insert “R.N” before the word “license” to conform to §4.1.2.

Third, §§6.1.1, 6.1.2, 6.1.3, and 6.1.4 contain a plural pronoun (“their”) with a singular antecedent (“educator”). This could be corrected by simply substituting “Educators” for “An educator” in §6.1.

I recommend sharing the above observations with the Professional Standards Board, DOE, and SBE.

10. DOE Proposed Accountability Regulation [14 DE Reg. 347 (November 1, 2010)]

The Department of Education maintains accountability regulations implementing federal law and Title 14 Del.C. §§154-155. Schools which are determined to be underperforming based on objective criteria may be classified as “under improvement”. See 14 DE Admin Code Part 103, §§2.11.5 and 6.0. The consequences of such classification are reflected in the attached DOE table captioned “School Improvement Consequences by Years Under Improvement”.

The DOE proposes to dilute the consequences and oversight of schools designated “Under Improvement Phase 1” by deleting the following requirement:

7.1.2. Utilize the Department’s Comprehensive Success Review process, which includes an audit tool, an on site visit, and feedback on strengths and opportunities for improvement; ...

The DOE’s rationale for deletion is as follows: 1) “feedback” from the deficient schools (“intended participants”) which would logically prefer less oversight; 2) “resource concern” (despite the federal award of \$119 million in “Race to the Top” funds); and 3) “additional flexibility”. Consistent with the attached excerpt from the DOE’s website, one of the four purposes of the “Race to the Top” funding is “turning around our lowest-achieving schools”. A reasonable person might view the deletion of §7.1.2 as “backsliding” rather than “racing to the top”.

Moreover, although the regulatory synopsis suggests that “Change Management work” may provide equivalent results (p. 347), the regulation itself simply deletes the requirement of participating in a review process and substitutes nothing. An “Under Improvement Phase 1” school need only review and modify its School Improvement Plan. The former DOE oversight through on-site visit, school completion of audit, and DOE feedback are deleted altogether with nothing substituted to reflect DOE involvement or oversight.

If the Department opts to effect the deletion, it should consider correcting the grammar in §7.1 by adopting the following substitute §7.1.2: “If a school is designated Title I, offer ESEA choice.”

I recommend sharing the above observations with the DOE and SBE.

11. Office of Highway Safety Proposed DUI Fee Regulation [14 DE Reg. 419 (11/1/10)]

The Office of Highway Safety proposes to adopt a revised set of standards for “drinking driver programs”. The main thrust of the regulation is to authorize providers to increase fees charged to offenders for DUI evaluation, education, and referral. The OHS notes that providers have not been authorized to increase fees since 2001.

I have the following observations.

First, the regulation substitutes “DSAMH” for “DADAMH” in several sections. However, the OHS overlooked “DADAMH” references in §§6.4 and 6.4.5.

Second, the fee schedule in Regulation 1201, §7.0 (p. 421) does not match the fee schedule in Regulation 1204, §7.0 (p. 431). I infer that the schedules should be consistent. The following are inconsistent:

Regulation 1201	Regulation 1204
No Show (Education) - \$25.00	No Show (Education) - \$25.00 \$35.00
No Show (Treatment Group)- \$25.00	No Show (Treatment-Group) - \$25.00 \$35.00
No Show (Treatment Individual)- \$25.00	No Show (Treatment-Individual) - \$25.00 \$35.00
Administrative Reentry (Programs)- \$25.00	Administrative Re-Entry (Programs) - \$25.00 \$35.00
Administrative Re Screening - \$65.00	Administrative Re-screening - \$35.00
Hardeore Program- \$25.00	Hardcore Program - in development

Third, there are a few references “implying” that fees should not be charged if an offender has a valid excuse/good cause for missing an appointment. See, e.g., Regulation 1201, §4.5; and Regulation 1204, §4.1.1.3.1. However, many sections simply refer to fees for missed appointments with no reference to a valid excuse/good cause. See, e.g., Regulation 1201, §7.0; and Regulation 1204, §§4.1.1.5.2, 5.1.2.2, 5.2.3.2, 5.2.3.3, and 7.0. Regulation 1201 has no definition of “no show”. Regulation 1204, §2.0, has a definition of “no show” which is “weak” in the context of extenuating circumstances (e.g. an offender would be charged a “no show” fee even if absence were due to an emergency hospitalization, agency scheduling error, or late arrival of bus or paratransit).

I recommend sharing the above observations with the OHS.

12. Office of Hwy. Safety Motorcycle Helmet & Eye Protection Reg. [14 DE Reg. 432 (11/1/10)]

Consistent with the attached Title 21 Del.C. §4185, motorcyclists up to 19 years of age must ride with a helmet and eye protection approved by the Secretary of the Dept. Of Safety and Homeland Security. Riders age 19 and above must wear the Secretary-approved eye protection and carry the Secretary-approved helmet on the motorcycle. The Office of Highway Safety is now issuing a revised implementing regulation.

I have the following observations.

First, the National Highway Safety Administration maintains a motorcycle helmet regulation codified at 49 C.F.R. 571.218. Its website contains a 66 page notice of proposed rulemaking which contains a comprehensive discussion of the advantages of helmets and issues related to helmet mislabeling and enforcement of helmet laws. For example, the NPR contains the following information: 1) helmets have an overall effectiveness of 37% in preventing fatalities in potentially fatal crashes (p. 8); and 2) riders who crash without helmets are 3 times more likely to have brain injuries (p. 9).

Second, there is a major problem with “novelty helmets” and fake “DOT” stickers. Some motorcyclists affix “DOT” stickers obtained from retailers to their helmets to create the appearance of properly certified, compliant helmets. Enforcement is difficult since the sellers assert that the letters simply stand for “Doing Our Thing” (p. 14). Even in states with mandatory helmet laws, “non-compliant helmets were used by 15% of motorcyclists” (p. 9). The NPR proposes several safeguards to improve helmet safety, including manufacturers placing the DOT symbol under the clear coat of the helmet, including the word “certified” on the helmet, and including manufacturer model, date of manufacture, and other information prominently on the outside of a helmet. However, it is unclear if the NPR (which is undated) was ever issued. In any event, the Code of Federal Regulations (CFR) still contains the 1988 version of the regulation. An excerpt is attached.

Third, in §1.1, for improved grammar, substitute “are as follows” for “are ones that”.

Fourth, since the federal standards may change, the OHS may wish to insert “most current” before the phrases “Federal Motor Vehicle Standard (FMVSS) 218” and “Federal Motor Vehicle Safety Standard 218”. Otherwise, someone could argue that the State is adopting the version in effect in 2010 rather than any updated version.

Fifth, §§1.2.1 and 1.2.2 are ostensibly “surplusage” since §1.1 requires riders to comply with the federal “218” standard and §§1.2.1 and 1.2.2 quote almost verbatim from the federal “218” standard. Compare §1.2.1 with 49 C.F.R. 218 - S.5.6.1 and §1.2.2 with 49 C.F.R. 218 - S.5.6.1(f). Incorporating the language in the current federal regulation could present a problem if the federal standards change.

Sixth, it would be preferable to address the novelty helmet and fake DOT sticker issue in the regulation. Assuming deletion of §§1.2.1 and 1.2.2 pursuant to the above paragraph, consider inserting a new §1.2.1 to read as follows:

1.2.1. Without limitation, the following helmets are categorically disapproved:

- 1.2.1.1. “Novelty” helmets which do not meet or exceed the standards in §1.1.1;
- 1.2.1.2. Helmets affixed with a DOT symbol not installed by the helmet’s manufacturer; and
- 1.2.1.3. Helmets with counterfeit labels in lieu of the label affixed by the helmet’s manufacturer pursuant to the federal standards identified in §1.1.1.

I recommend sharing the above comments with the OHS and the SCPD’s BIC.

13. VCAP Proposed Payment of Claims Regulation [14 DE Reg. 383 (November 1, 2010)]

The Victims’ Compensation Assistance Program (“VCAP”) pays approved medical claims for crime victims. The federally-funded VCAP is the payor of last resort and covers costs not paid by private insurance, Medicaid, or Medicare. The VCAP adopted a comprehensive set of procedural regulations in March, 2010. It now proposes to adopt a single new regulation covering payment of claims. The DLP was involved with the drafting of the new regulation and it generally incorporates recommended language.

First, the regulation establishes that a provider receiving VCAP payment accepts it as payment in full. There was a concern whether out-of-state providers might not uniformly honor that aspect of the regulation. For example, if a patient signs a standard agreement to pay for services of an out-of-state provider, it may recite that the patient agrees to pay 100% of charges regardless of insurance or third party coverage and that the laws of X state govern the relationship. Under such circumstances, the out-of-state provider could argue that the patient is subject to balance billing, i.e., the difference between the 80% of usual/customary charges and the full bill. To provide increased consumer protection, the last sentence in §28.1 authorizes the VCAP to include a notice accompanying payment that “provider acceptance constitutes acknowledgment of payment in full.” This provides additional protection to the patient through contract and estoppel defenses to provider balance billing claims.

Second, there was a concern that the regulation protect not only the victim from balance billing, but also other third parties (e.g. parent; guardian). The regulation addresses this by disallowing balance billing of the “victim or third parties”.

Third, there was a concern that providers occasionally may receive less than 80% of the usual/customary charge if payment in that amount would exceed the aggregate compensation cap set by statute or regulation. That possibility is addressed in §28.2 through the following sentence: “The VCAP may pay a lesser amount if payment under this section would exceed a statutory or regulatory cap.”

All in all, the regulation is straightforward and easy to understand. Its rate of compensation (80% of the usual and customary charge), compared to insurance, Medicaid, and Medicare, is fair. Finally, it includes sufficient protection from balance billing to the victim and third parties. I recommend endorsement.

14. DVR Mileage Policy

The Division of Vocational Rehabilitation (“DVR”) compiles many of its administrative standards in an unpublished “Casework Manual”. The DLP, with support from the Client Assistance Program (CAP) presented the attached memorandum to DVR’s Policy Committee on October 27. In a nutshell, the DLP is promoting amendments to the DVR transportation reimbursement standard. The Committee agreed to take the recommendations under advisement.

I would like the SCPD to endorse the DLP’s recommendations and forward a conforming letter to the Committee with a courtesy copy to the DVR Director and Deputy Director.

Attachments

8g:misc/1110bils
F:pub/bjh/legis/2010p&l/1110bils