

MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory Initiatives

Date: January 9, 2011

I am providing my analysis of seventeen (17) regulatory initiatives in anticipation of the January 13 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. Office of Hwy. Safety Final Motorcycle Helmet & Eye Protection Reg. [14 DE Reg. 670 (1/1/11)]

The SCPD and GACEC commented on the proposed version of this regulation in November, 2010. The GACEC's November 29 letter is attached for facilitated reference. The Office of Highway Safety has now adopted a final regulation with few changes.

First, the Councils included some statistics on the value of helmets in decreasing fatalities and brain injuries. The OHS acknowledged that NHTSA studies confirm the accuracy of the statistics.

Second, the Councils recommended a grammatical change in §1.1. The OHS did not address the comment in the final regulation and no amendment was effected.

Third, the Councils recommended that OHS consider inserting "most current" before the cross reference to the Federal Motor Vehicle Standard 281 to obviate an argument that the State is adopting the version in effect in 2010 irrespective of subsequent revisions. OHS commented as follows:

The Governor's Advisory Council for Exceptional Citizens and the State Council for Persons with Disabilities both suggested inserting the language "most current" before the phrase "FMVSS 218" throughout the regulation in the event the existing Federal standard changes. The Department agrees this is a logical inclusion in the regulation and will add the recommended language.

Unfortunately, the text of the final regulation omits the "most current" reference.

Fourth, the Councils noted that §§1.2.1 and 1.2.2 were "surplusage". No change was made.

Fifth, the Councils recommended the addition of the following provision:

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 in §1.1.1.

The OHS responded to this recommendation as follows:

The Department rejects the request to amend the regulation as outlined above. While the Department recognizes the escalating problems with novelty helmets, if applied as outlined in Exhibit A, this regulation will not recognize novelty helmets are acceptable.

This is an odd response. The regulation defines the scope of acceptable helmets and requires helmets used by motorcyclists in Delaware to meet the federal standards. OHS acknowledges an “escalating problem” with non-compliant novelty helmets. It then essentially says it does not wish to characterize non-compliant novelty helmets, including those with counterfeit stickers and DOT symbols, as unacceptable. The implication is that use of such novelty helmets in Delaware is just fine. The only novelty helmets proscribed under the proposed provision are those which are federally non-compliant and the provision would facilitate enforcement.

At a minimum, the Councils may wish to informally advise the OHS of the omission of the “most current” language in the text of the final regulation. The SCPD may also wish to consider the merits of following up with the Department Secretary to encourage reconsideration of the novelty helmet provision.

2. VCAP Final Payment of Claims Regulation [14 DE Reg. 666 (1/1/11)]

The SCPD and GACEC commented on the proposed version of this regulation in November, 2010. Both councils endorsed the standards which had been previously edited by the DLP prior to publication. The Victim Compensation Assistance Program has now acknowledged the endorsements and adopted a final regulation with no further changes.

3. DOE Final Accountability Regulation [14 DE Reg. 647 (1/1/11)]

The SCPD and GACEC commented on the proposed version of this regulation in November, 2010. A copy of the GACEC’s November 18 letter is attached for facilitated reference.

First, the Councils expressed concern with dilution of the accountability review process for schools designated “Under Improvement Phase I”. The Department of Education effected no change based on the rationale that the lack of mandatory standards provides the DOE with flexibility in addressing district weaknesses.

Second, the Councils recommended a grammatical edit to §7.1.2. The DOE adopted the

suggested sentence verbatim.

I recommend no further action.

4. DMMA Final Citizenship & Alienage Regulation [14 DE Reg. 654 (1/1/11)]

The SCPD and GACEC commented on the proposed version of this regulation in November, 20, 2010. The Councils endorsed the regulation which was essentially a “housekeeping” provision to conform a regulation adopted on June 1, 2010 with CMS guidance issued on July 1, 2010. The Division of Medicaid and Medical Assistance has now acknowledged the endorsements and adopted a final regulation with no further changes.

I recommend no further action.

5. DMMA Final Public Assistance Reporting Information System Reg. [14 DE Reg. 658 (1/1/11)]

The SCPD and GACEC commented on the proposed version of this regulation in November. The SCPD’s November 30 memo is attached for facilitated reference. Both councils endorsed the regulation since State participation in the PARIS is federally required to qualify for funding for automated data systems. The SCPD included the following additional inquiries:

Does the DMMA utilize the PARIS system for other public benefits (e.g. food stamps)?

Does the DMMA use PARIS as a tool to identify individuals who have not applied for Medicaid coverage, but who may be eligible based on their income?

The Division of Medicaid & Medical Assistance responded as follows:

DMMA appreciates your endorsement. In response to your additional questions, data matching is run on all public benefit programs. Also, Federal law requires states to use PARIS when determining Medicaid eligibility; other reasons/situations are not identified. And, although, PARIS is an information sharing system that shares public assistance data among States to detect/deter and prevent improper payments, the information shared is limited to whether an individual is collecting benefits in more than one State, including VA benefits.

At 660. [emphasis supplied]

Since the regulation is final, and DMMA responded to the SCPD’s inquiry, I recommend no further action.

6. DMMA Final Child Eligibility for GA and TANF Regulation [14 DE Reg. 661 (1/1/11)]

The SCPD and GACEC commented on the proposed version of this regulation in November.

The Councils identified a single concern, i.e., deletion of provisions related to eligibility of young adults to GA. The Division of Medicaid & Medical Assistance has now adopted a final regulation with no changes. DMMA indicates that the deleted sections are unnecessary since eligibility of young adults is covered by other regulations. At 662-663.

I recommend no further action.

7. DMMA Final Medicaid & CHIP Quality Assurance Regulation [14 DE Reg. 650 (1/1/11)]

The SCPD and GACEC submitted sixteen (16) comments on the proposed version of this regulation in November, 2010. The Division of Medicaid and Medical Assistance has now adopted a final regulation incorporating six (6) amendments and providing clarifying commentary in other contexts. DMMA provided the following compilation of each of the sixteen (16) comments and its response. The Councils may be most interested in the following: 1) Item 9, clarifying the availability of no-cost second opinions; and 2) Item 10, clarifying that “MCOs provide site visits to all new PCPs to assure wheelchair accessibility”. Although I continue to differ with DMMA on a few items (e.g. Item 14), I recommend either no further action or issuance of a “thank-you” letter for considering the Councils’ commentary.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

1. The Governor’s Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medicaid Assistance (DMMA) has considered each comment and responds as follows.

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 erroneous.

Agency Response: The word “address” was corrected to “access”.

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.

Agency Response: DMMA appreciates your comments on this issue.

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”.

Agency Response: The division name has been 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.

Agency Response: The QMS has been written to be generic enough to be all inclusive of the many groups which spend Medicaid dollars. The quality management structure diagram has been updated to reflect the new name change for the Division of Prevention and Behavioral Health Services. DMMA appreciates your comments on this issue.

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...” We believe the reference should be to “under 200% of the Federal Poverty Level (FPL)”.

Agency Response: QMS updated to correctly reflect the reference 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. We believe DMMA rescinded that bar earlier this year. See 13 DE Reg. 1540 (June 1, 2010).

Agency Response: Delaware has implemented the option under Section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) known as CHIPRA, to provide coverage to noncitizen children regardless of their date of entry into the U.S. This has been updated in the QMS.

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”. Does DMMA have a template for such plans or does each MCO have its own criteria? If DMMA does not have a template or standards, it could consider adopting them.

Agency Response: DMMA does not have a template for the treatment plan. Both MCOs contracted by DMMA are nationally certified by the National Committee for Quality Assurance (NCQA) and operate under their nationally approved and recognized standards. DMMA accepts the standards approved by this national accrediting body.

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, we recommend that DMMA include such review in assessing MCOs.

Agency Response: DMMA does include fair hearing results in its assessment of 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. We have not seen this aspect of MCO coverage advertised. Are there standards which define eligibility for a second opinion? If so, we respectfully request a copy.

Agency Response: Any member is eligible for a second opinion. The requirement is a Prior Authorization if the provider is out of network. This information is discussed in the Member Handbook provided to all members.

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. How does DMMA assess MCO compliance with the mandate? Do MCOs survey their providers on accessibility, provision of interpreters for the Deaf, etc?

Agency Response: DMMA has amended the reference to read “Titles II and III of the Americans with Disabilities Act”. MCOs provide site visits for all new PCPs to assure wheelchair accessibility. Translation services are provided to members as outlined in the Member Handbook.

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.

Agency Response: Language is consistent with 42 CFR §438.210©.

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”.

Agency Response: The sentence has been revised to “ The State is not required to obtain written approval from a member before requesting the member’s record from the primary care provider or any other provider and she 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.”

Agency Response: DMMA agrees that this sentence is awkward, but it follows the CFR language without changing the intent of the regulation. DMMA clarifies that the intent is for the MCOs to ensure that those individuals who make decisions on grievances and appeals are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee’s condition or 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”.

Agency Response: Language in the QMS is consistent with the 42 CFR §438.420.

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.

Agency Response: DMMA has reviewed the C. F. R. 438.10 and references section (d)Format, (1), (I), and (ii), and which includes that “The State expects the MCO will assure that written material uses : (I) easily understood language and format at a sixth grade level; and (ii) written materials are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited..... and (2) The MCO will inform all enrollees and potential enrollees that information is available in alternative formats. The MCOs provide Interpretive Services which are designed to assist members who have special needs including speech, hearing, sight, etc. The Delaware Relay Services for Hearing –Impaired Members is a free service available 24 hours a day.

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 contains 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 2009 (sic “2009) while Unison stayed steady at 27.55 percent in 2008 and 27.95 percent in 2009.

We respectfully request more specifics on mental health treatment data since it appears that MCOs may be “falling short”.

Agency Response: DMMA appreciates this feedback and will explore ways to include in the MCO monitoring and evaluation processes going forward.

8. DMMA Prop. PASRR Regulation [14 DE Reg. 615 (1/1/11)]

As background, Congress enacted legislation in the 1980s and 1990s to address “dumping” of persons with mental retardation (a/k/a intellectual disability) and mental illness in nursing homes. Federal law requires screening of persons with mental illness, mental retardation, or related conditions prior to admission to a Medicaid-certified nursing facility. The State has implemented this requirement by conducting Pre-admission Screenings and Resident Reviews (PASRR). DMMA is now adopting a regulation which further defines responsibilities and the process.

I have the following observations.

First, the regulation is inconsistent. It sometimes mentions “related conditions” (PAS POL 20102.3.1, §3) and sometimes omits the reference (PAS POL 20102.3; and PAS POL 20102.3.1, §§2 and 5). DMMA may wish to insert a reference to “related conditions” in the sections in which the reference is omitted. Alternatively, some states subsume “mental retardation and related conditions” under the rubric of “developmental disability” which is defined. See attached Wisconsin form. Other states (e.g. N.C.) use acronyms of MI, MR, and RC. Delaware’s DLTCRP refers to screening of individuals with “mental illness, mental retardation, and developmental disabilities”. See 16 DE Admin Code 3201, §6.3.4.

Second, in PAS POL 20102.3.1, §7, it is particularly important to include a reference to “related conditions” to ensure that DDDS is not only reviewing to identify mental retardation to the exclusion of TBI, autism, etc. Section 7 would also benefit from inclusion of a sentence similar to the first sentence in §6. Consider some variation of the following: “DDDS will assess individual and review documentation to verify whether the individual meets diagnostic criteria of mental retardation or related condition.”

Third, PAS POL 20102.3.1, §10 indicates that DMMA will issue the final determination letter. It would be preferable to include a recital that the letter (a/k/a “notice”) will include appeal rights. Parenthetically, there appears to be some inconsistency between the §10 recital that DMMA will issue the final determination and the DSS regulation reproduced below contemplating appeals of the DSAMH and DDDS decisions to DSS with no mention of DMMA decisions. DMMA may wish to review this ostensible inconsistency with DSS.

5304.1 Jurisdiction for PASARR Hearings

1. An individual who has been adversely affected by any determination made by either the Division of Mental Health (DMH) or the Division of Developmental Disabilities Services (DDDS) as a result of a pre-admission screening or an annual resident review (PASARR) of any applicant for or recipient of residential nursing services may appeal the determination decision under these rules. The hearing will be conducted by the Division of Social Services and the hearing decision is binding on the Department of Health and Social Services. For hearings on PASARR determinations which have a specific affect on Medicaid Program eligibility, DSS will appear as a witness for DDDS or DMH if requested by a party to the hearing. For appeals initiated by non-Medicaid claimants or appellants, the State's case will be presented by DDDS or by DMH as appropriate.

I recommend sharing the above observations with DMMA.

9. DSS Prop. Food Supplement Program Verification Reg. [14 DE Reg. 620 (1/1/11)]

The Division of Social Services proposes to revise its verification standards in the Food Supplement Program in several contexts (e.g. disability; income; expenses; residency).

I have the following observations.

First, there are multiple consumer-oriented provisions. For example, §1.B.1 recites as follows: “If an alien does not wish DSS to contact INS to verify his or her immigration status, give the household the option of withdrawing its application or participating without that member.”

Second, §1.H. 1 could be cause for concern. It recites as follows: “The disability must be one considered permanent under the Social Security Act.” The Social Security Administration general standard for SSI and SSDI benefits is that the disability must either be expected to last for at least 1 year or result in death. See attached Q&A document. The second SSA attachment recites as follows:

Most of the listed impairments are permanent or expected to result in death, or the listing includes a specific statement of duration is made. For all other listings, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

In many cases, an individual will not know the precise “listing” upon which his/her SSI/SSDI benefits are based. Moreover, individuals may be found eligible if their condition(s) do not meet a listing but are functionally equivalent to a listing. Unless USDA regulations require DSS to limit disability eligibility to SSI/SSDI beneficiaries with a “permanent” disability as juxtaposed to beneficiaries awaiting death or with 12-month+ conditions, I recommend amending this section. Consider the following alternative: “The disability must be one considered permanent or expected to last more than 12 months or result in death under the Social Security Act.”

Third, in §1.H.2.ii, consider substituting “chronic” for “permanent”. Alternatively, consider the following substitute: “...s/he suffers from some other severe physical or mental disease or non-

disease related disability considered permanent or expected to last more than 12 months or result in death.”

Fourth, in §1.H.2.ii, consider the following amendment: “...statement from a physician, advanced practice nurse, or licensed or certified psychologist...”. As a practical matter, many individuals are now primarily treated by an advanced practice nurse rather than a traditional physician. Advanced practice nurses are authorized to perform independent acts of diagnosis and prescribe drugs. See Title 24 Del.C. §1902(b)(1). State law bars health insurers from denying benefits for eligible services when provided by an advanced practice nurse instead of a physician. See Title 18 Del.C. §2318. The attached December 28, 2010 News Journal article underscores that many individuals are primarily treated by advanced practice nurses.

I recommend sharing the above observations with the Division.

10. DSS Prop. Fair Hearing Practices & Procedures Reg. [14 DE Reg. 618 (1/1/11)]

The Division of Social Services proposes to comprehensively revise its fair hearing practices and procedures regulation. DSS recites as follows:

These rule changes are being made to simplify language and to re-order content for clarity and ease of use. Specifically, the following policy sections are reformatted and reworded for clarity with no change in content: [list of 22 sections].

DSS also notes that 4 other sections were revised.

I have the following observations.

First, DSS is deleting parenthetical language in existing §5001 which clarifies that a hearing may be requested based on suspension, reduction, overpayment, sanctions, delays, and terminations. This was a useful clarification and I recommend that it be inserted in new §5001, Par. 1.

Second, in §5300, DSS should consider adding a reference to disclosure of agencies providing free legal representation as a feature of an “adequate” notice. Cf. 7 C.F.R. 273.15(f).

Third, §5300, Par. 2.A.6 is not literally accurate. It categorically recites “(i)f the agency action is upheld, that such assistance must be repaid.” Repayment is discretionary and the State or MCO can decide to not pursue recovery. The analogous federal regulation [42 C.F.R. 431.230(b)] states that the agency “may institute recovery”. Moreover, a beneficiary can elect to not continue benefits during the pendency of appeal. See §5308, Par. 2.A and §5300, Par. 2.C. Finally, this section would literally impose a mandatory repayment duty for benefits received prior to issuance of the notice and during the minimum 10-day notice period.

Fourth, in §5300, Par. 2.C., I recommend inserting “potential” prior to “liability”. As noted in

the preceding paragraph, pursuing repayment is discretionary with the State or MCO. “Benefits are subject to recovery” [§5308, Par. 1] but the agency has discretion to not impose retroactive liability.

Fifth, §§5304, Par. 2 and 5305, Par. 1 categorically require hearing requests to be in writing. Food Supplement Program hearing requests can be submitted orally. See 7 C.F.R. 273.15(h). The Division may wish to revise this regulation to include that exception.

Sixth, §5304.1 contemplates PASARR decisions being issued by DDDS and DSAMH. Proposed DMMA regulations would change the decision-making to DMMA. See 14 DE Reg. at 615, 618 (1/1/11).

Seventh, in §5304.1, substitute “effect” for “affect”.

Eighth, in §5305, Par. D.1, the description of “timely notice period” is inaccurate since it categorically states it is a 10-day period. A notice can be provided which gives more than a 10-day notice. The 10 days is a “minimum” which an agency or MCO may exceed. See, e.g., 42 C.F.R. 431.211 and §5300, Par. B. If an MCO mailed out a notice with an effective date of 15 days from notice date, the “timely notice period” would be 15 days, not 10 days. Reduction or termination of benefits would be barred within that 15 day period, not a 10 day period.

Ninth, §5305, Par. 3, literally gives the hearing officer no authority to accept a fair hearing request beyond the 90-day period beginning with the effective date of action regardless of cause. Thus, even if a beneficiary does not receive a notice of action based on the MCO mailing it to a wrong address or wrong person, the beneficiary is without a remedy. In contrast, a hearing officer has authority to extend hearing timelines for “good cause”. See §5311, Par. 3, Subsection 3 and §5308, Par. 2.C.1. The hearing officer should be authorized to allow an untimely fair hearing request based on “good cause”.

Tenth, the interplay between §5311, Par. 2 (contemplating mailing of hearing notice 12 days prior to hearing) and §5403, Par. 2 (giving staff 5 working days to respond to a beneficiary’s request for documents) is problematic. By the time the beneficiary receives the notice of hearing disclosing the right to access “the record”, there is no time to arrange for copies prior to hearing. Hearing notices should be issued more than 12 days prior to hearing.

Eleventh, §5311 should be amended to specifically require that notices be sent to both the appellant and his/her attorney or representative. For example, Par. 3., Subsection 1, literally authorizes mailing of the notice to the appellant with no notice to the attorney. This ultimately results in delayed receipt by counsel. When coupled with only a 12 day advance notice period, the regulation promotes last-minute requests for continuances and undermines effective representation.

Twelfth, in §5311, Par. 3, it would be preferable to include a disclosure of right to access

“case records” apart from the documents the agency or MCO has submitted as part of the Fair Hearing summary (the “record”). For example, an agency or MCO may not submit documents which undermine its position to the hearing officer but they may be in its case records. Access is a beneficiary’s right and should be disclosed in the hearing notice. See §5403, Par. 2.

Thirteenth, in §5312, the introduction recites that the policy applies to decisions made by DSS or DMMA. There is no comparable provision covering MCOs which also issue appealable decisions. The regulation covers “Medicaid Managed Care Cases” [§5304, Par. 1.B; §5401, Par. C.6]. I believe the superseded version of §5312 contained references such as “if completed by DSS” because it contemplated MCOs responding to hearing requests in addition to the State. The new version solely contemplates “State Agency” preparation of the hearing summary, etc. which has not been the historical practice for appeals from MCO decisions. MCOs have traditionally been required to prepare their own Fair Hearing summaries.

Fourteenth, §5312, Par. 2.E, is inadequate since it only requires citation to “State rules”. The agency is required to disclose “(t)he specific regulations that support, or change in Federal or State law that requires, the action” [42 C.F.R. 431.210]. The hearing decision is based on “State and federal laws and regulations.” See §5500, Par. 3.

Fifteenth, superseded §5312, Par 4, contained the following consumer-oriented guidance: “The document must be easily read and understood (abbreviations should be avoided).” It would be preferable to retain this guidance in the new version.

Sixteenth, §5401 contains the following limitation for Food Supplement Program appeals:

DSS is not required to hold fair hearings unless the request for a fair hearing is based on a household’s belief that:

- A. Its benefit level was computed incorrectly
- B. The rules were misapplied or misinterpreted

This is not accurate. For example, failure to timely process an application is appealable. Parenthetically, it is unfortunate that the recitation in the superseded regulation [clarifying that “failure to act with reasonable promptness” is appealable] is being deleted. The recital should preferably be retained. It is retained in the Medicaid context. See §5401, Par. C.1. It is retained in the cash assistance context. See §5401, Par. B.1. Moreover, the USDA discourages such categorical limitations on appeals:

If it is unclear from the household’s request what action it wishes to appeal the State agency may request that the household clarify its grievance. The freedom to make a request for a hearing shall not be limited or interfered with in any way.

7 C.F.R. 273.15(h). [emphasis supplied]

Seventeenth, the grammar in §5401, Par. C could be improved. Subparts 1-4 are sentences while Subparts 5-7 are not sentences and literally state that a “hearing is received”. It reads, in

pertinent part, as follows:

The State agency must grant an opportunity for a hearing when:

- ...5. Received from prepaid ambulatory plan...
- 6. Received from any managed care organization...
- 7. Received from any enrollee...

The comparable federal regulation [42 C.F.R. 431.220] does not reflect the same deficiency and should be reviewed.

Eighteenth, in §5402, Par. 1.F, the grammar merits correction. It reads as follows:

The Hearing Officer will conduct hearings regarding decisions on:

...F. Food Supplement Program households may appeal decisions concerning expedited service.

Nineteenth, in §5404, Par. G, the word “handicaps” is disfavored. Consider substituting “limitations” or “impairments”.

Twentieth, §5405 is being deleted with no substitute. It should be retained. It is important to have standardized hearing procedures and to clarify the burden of proof. The “Summary of Proposed Changes” section of the regulation does not indicate that this is a section which will be revised in the future. It is simply being deleted.

Twenty-first, the DHSS approach to resident hearings to contest a discharge or transfer from a nursing home remains extremely problematic. CMS regulations require DMMA, as the State’s “Medicaid agency” to provide a compliant hearing for residents who contest nursing home discharges and transfers:

- (a) The Medicaid agency must be responsible for maintaining a hearing system that meets the requirements of this subpart.
- (b) The State’s hearing system must provide for -
 - (1) A hearing before the agency;...

42 C.F.R. §431.205.

The State agency must grant an opportunity for hearing to the following:

- (3) Any resident who requests it because he or she believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged.

42 C.F.R. 431.220. See also 42 C.F.R. §206(c)(3).

Despite the above regulations, and Council objection, DSS discontinued offering such

hearings in August, 2008:

The rule is deleted from the Division of Social Services Manual as the Division of Long-Term Care Residents Protection (DLTCRP) now has jurisdiction over these types of hearings. Reference is made to DLTCRP's Patient's Bill of Rights, Appendix A of Regulation 3201, Nursing Home Regulation for Skilled Care and Regulation No. 3205, Nursing Home Regulations for Intermediate Care.

12 DE Reg. 243 (August 1, 2008)

The current proposed regulation still contains multiple sections contemplating application of the DSS regulation to nursing home discharge/transfer disputes:

Section 5001. Providing an Opportunity for a Fair Hearing

This policy applies to all applicants and recipients of DSS and DMMA services.

...2. Staff Inform Clients in Writing of Their Hearing Rights

...C. At the time a skilled nursing facility or a nursing facility notifies a resident that he or she is to be transferred or discharged.

Section 5401. Conducting Hearings on State Actions

This policy applies to DSS hearing officers any time an appellant/claimant requests a hearing due to an agency action.

C. Medical Assistance Hearings

The State agency must grant an opportunity for a hearing when:

...3. A resident believes a nursing facility has erroneously determined that he or she must be transferred or discharged.

At the same time, attempting to locate DLTCRP regulations defining procedures to receive and process resident challenges to nursing home discharge/transfer is, at best, a daunting endeavor. DSS cited to "DLTCRP's Patient's Bill of Rights, Appendix A of Regulation No. 3201" at 12 DE Reg. 243 (August 1, 2008). However, Appendix A has ostensibly never been published as a regulation. It does not appear in the Delaware Administrative Code. It does not even appear on the DLTCRP's Website. The DLTCRP incorporated some federal standards by reference into its regulations last year [13 DE Reg. 1322, 1323 (April 1, 2010)]. However, those regulations contain no hearing procedures and only require facilities to notify residents facing discharge/transfer of the general "right to appeal the action to the State". 42 C.F.R. §483.12(a)(6)].

Since the State Medicaid agency is required to maintain a hearing system with specific

standards conforming to 42 C.F.R. Part 431, Subpart E, I recommend that DSS maintain regulations for processing challenges to nursing home discharges/transfers, at least for “recipients of DSS and DMMA services” to whom the regulations apply [§5001]. Literally, the CMS regulations do not permit delegation of the hearing system by the Medicaid agency to another State agency. See above excerpts from 42 C.F.R. §§431.205- 431.206.

I recommend sharing the above observations with DSS. Given the importance of the regulation, the SCPD may wish to share a courtesy copy with the DHSS Secretary.

11. DOE Prop. Children with Disabilities Part 922 (Purposes & Def.) Reg. [14 DE Reg. 604 (1/1/11)]

The Department of Education proposes to revise its special education regulations to conform to changes made to federal regulations in 2008 and to correct minor typographical errors. Part 922 encompasses “purposes and definitions”. I have included some comments on sections not earmarked for revision since the APA allows agencies to effect the following amendments informally:

- Nonsubstantive changes in existing regulations to alter style or form or to correct technical errors
- Amendments in existing regulations to make them consistent with changes in basic law but which do not otherwise alter the substance of the regulations

Title 29 Del.C. §10113(b).

1. In §2.2.4, substitute “Correction” for “Corrections”. The correct reference is Department of Correction. See Title 29 Del.C. §8901.

2. In §3.0, there are references to “mental retardation” in the definition of “Child with a Disability”, definition of “Mental Retardation”, definition of “Multiple Disabilities”, and definition of “Specific Learning Disability”. The corresponding federal regulation [34 C.F.R. 300.8] still uses the term “mental retardation”. The pending “needs-based funding legislation (H.B. No. 1) uses the term “mental disability” in lieu of the term “mental retardation” at Section 41. Moreover, other DOE regulations use the term “mental disability”. See, e.g., 14 DE Admin Code 928, §3.2.3 and 3.3.1; and 14 DE Admin Code 925, §6.12. At a minimum, the DOE may wish to consider adding an italicized sentence or note to the end of the definition of “mental retardation” as follows: “The terms ‘mental disability’ or ‘intellectual disability’ are sometimes used as substitutes for the term “mental retardation” and shall be considered equivalent terms for purposes of this regulation.” Given the use of the term “mental disability” in the 925 and 928 regulations, the DOE could also consider inserting a discrete definition of the term.

3. In §3.0, there are definitions of “Deafness” and Hearing Impairment”. However, the term “hard of

hearing” is used in §3.0, definition of “Interpreting Services”. It is also used in Title 14 Del.C. §§3112 and 1331(c) as well as 14 DE Admin Code 1574 (Teacher of Students Who Are Deaf or Hard of Hearing). At a January 5 meeting involving the DOE’s special education director and counsel, consensus was reached on using the term “hard of hearing” in the context of a proposed regulation covering interpreter/tutors. The DOE should therefore consider adding an italicized sentence or note to the end of the definition of “hearing impairment” as follows: “The term ‘hard of hearing’ is sometimes used as a substitute for the term ‘hearing impairment’ and shall be considered an equivalent term for purposes of this regulation.”

4. In §3.0, definition of “Core Academic Subjects”, the DOE should consider substituting “world languages” for “foreign languages”. See 14 DE Reg. 555 (12/1/10).

5. In §3.0, the definition of “Free Appropriate Public Education” does not include State-law enhancements in Title 14 Del. §3101 amended in 2010 by H.B. No. 328. This is a major omission. They should be incorporated into the regulation.

6. In §3.0, the definition of “Services Plan” is difficult to follow and could benefit from a review of grammar.

7. In §3.0, the definition of “Consent” omits the FERPA requirements of dating and recitation of purpose of disclosure for consent to disclosure of records. Compare 34 C.F.R. §99.30.

I recommend sharing the above observations and recommendations with the DOE and SBE. The Council should also consider sharing the recommendation concerning Item 5 with the Lt. Governor and prime sponsor of H.B. 328, Rep. Q. Johnson. These public officials may wish to support the recommendation.

12. DOE Prop. Children w/Disabilities Part 928 Funds Use & Admin. Reg [14 DE Reg. 614 (1/1/11)]

The Department of Education proposes to amend its special education regulation concerning use and administration of funds to conform to federal regulations. The only change in this section is deletion of an audit handbook no longer in use. The change is benign. I recommend endorsement subject to sharing the observation that many references to units (e.g. §3.2.3) will be inaccurate once the needs-based funding legislation (H.B. No. 1) is enacted.

13. DOE Prop Children w/Disabilities Part 927 Monit/Enforce/Confid Reg [14 DE Reg 612(1/1/11)]

The Department of Education proposes to amend its special education regulation in the context of monitoring, enforcement, and confidentiality of information. I have five (5) observations compiled below. Parenthetically, although the recommendations address specific sections that may not be earmarked in the regulation for revision, the DOE may adopt revisions pursuant to either of the following APA exemptions:

- Nonsubstantive changes in existing regulations to alter style or form or to correct technical errors; or

- Amendments in existing regulations to make them consistent with changes in basic law but which do not otherwise alter the substance of the regulations.

Title 29 Del.C. §10113(b).

First, in §§4.1.2, 4.1.3, and 4.2.2.3, the reference to “sub grants” or sub grant” should be “subgrants” or subgrant”. See 34 C.F.R. §§300.228 and 300.705.

Second, at the end of §13.0, the “Authority” section should be amended to include a reference to 14 Del.C. §3130.

Third, §17.1 could be improved to more closely align with the enabling statute. Title 14 Del.C. §3130(b) recites as follows:

(b) The parents shall have the right to obtain copies of all records, except the actual evaluation or examination instrument, described in subsection (a) of this section either without charge, or, at the discretion of the district or state agency, at a fee not to exceed actual cost. Under no circumstances shall a fee be assessed which effectively prevents parents from exercising their right to inspect, review and copy records.

This statute does not create a presumption or norm of charging parents a fee for records. In contrast, the regulation creates such a presumption or norm. The regulation literally does not authorize an agency to provide records at no charge unless the charge would effectively prevent parents from exercising their right to inspect, review and copy records.

17.1. Each participating agency may charge a fee for copies of records that are made for parents under these regulations if the fee does not exceed the actual cost of the records, or effectively prevent the parents from exercising their right to inspect, review, and copy the records.

I recommend that the following be substituted to conform to the statute:

17.1. Each participating agency may either provide copies of records without charge or subject to a fee not to exceed actual costs. Under no circumstances shall a fee be assessed which effectively prevents parents from exercising their right to inspect, review and copy records.

Fourth, although §22.1 refers to “FERPA at 34 CFR part 99”, it would be preferable to include a reference to the FERPA regulation in the “Authority” section at the end of §22.0.

Fifth, the FERPA regulation requires the parental consent contemplated in §22.0 to be signed and dated, specify the records to be disclosed, state the purpose of disclosure, and identify to whom disclosure can be made. 34 C.F.R. 99.30. Section 22.0 omits these provisions and there is no definition of “parental consent” in the regulation. Parenthetically, the definition of “consent” in Regulation 922 is incomplete since it does not require dating of the consent nor recitation of the purpose of disclosure. The DOE should consider including a clarifying amendment to conform to the FERPA regulation.

I recommend that the above observations be shared with the DOE and SBE.

14. DOE Prop. Children w/Disabilities Part 926 Proc. Safeguards Reg. [14 DE Reg. 610 (1/1/11)]

The Department of Education proposes to amend its special education regulation covering procedural safeguards. I have the following observations.

First, §3.1.3 shortens the time period for providing notice to a parent of a disciplinary removal constituting a change in placement from 3 school days before the public agency proposes to change the child’s placement to 3 school days before the change in placement. The relevant federal regulation [34 C.F.R. 300.530(h)] contemplates provision of notice to the parent when the decision is made to make a removal. This equates more closely to the “proposal” date. Moreover, both the existing and proposed timeframes are ostensibly inconsistent with the “reasonable time” benchmark in 34 C.F.R. 300.503 and Title 14 Del.C. §3133. As a practical matter, if a school mails a notice to a parent, it could easily take a few days simply to reach the parent. In computing time, the court systems anticipate that mailing takes at least 3 days:

Additional time after service by mail. - Whenever a party has the right to or is required to do some act or take some proceeding within a prescribed period after being served and service is by mail, 3 days shall be added to the prescribed period.

Superior Court Civil Rule 6(e). If a child is to be excluded from his home school, the parent needs time to react (e.g. provide employer notice of need for vacation; consult attorney).

Second, in §11.0, it would be preferable to at least cross reference the new requirements in Title 14 Del.C. §3110(d) mandated by H.B. No. 387. The DOE issued a pre-publication draft implementing regulation on December 21. The same observation applies to §16.0. A district cannot file a civil action under this section without an affirmative vote of the local board.

Third, §12.1.1 is not very instructive. It would be preferable to include a note or other reference to the Delaware Supreme Court's Arons decision. Otherwise, the "cryptic" reference to "determined by State law" provides parents with no guidance even though the Delaware law is clear.

Fourth, in §30.2, some words are missing at the end. I believe the reference should be to "...change of placement pursuant to 36.0".

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

15. DOE Prop. Children with Disabilities Part 923 General Duties Reg. [14 DE Reg. 606 (1/1/11)]

The Department of Education proposes to amend its special education regulation in the context of general duties and eligibility of agencies. I have the following observations.

First, the regulation does not address children served prior to age three consistent with Title 14 Del.C. §3101(1)(2). See, e.g., §§1.2 and 24.1. There are multiple categories of children who are eligible for a FAPE at birth. See, e.g., Title 14 Del.C. §§1703(l) and 14 DE Admin Code 925, §6.6.3 (autism); Title 14 Del.C. §1703(m) and 14 DE Admin Code 925, §6.8.4 (deaf-blind); and Title 31 Del.C. §2501 and 14 DE Admin Code 925, §6.17 (blind/visual impairment). The DOE may wish to revise references to include children eligible at birth.

Second, the terms "sub grant" in §§33.1.1 and 33.1.2 should be "subgrant". See 34 C.F.R. §§300.228 and 300.705.

Third, in §52.1, the term "Sixty" should be "sixty".

Fourth, in §68.1.11, the word "Corrections" should be "Correction". The correct reference is Department of Correction. See Title 29 Del.C. §8901.

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

16. DOE Prop. Children with Disabilities Part 925 Eval/Elig/IEP Reg. [14 DE Reg. 609 (1/1/11)]

The Department of Education proposes to amend its special education regulation in the context of evaluations, eligibility determinations, and IEPs. I have the following observations.

First, in §20.2 the DOE is deleting some specific provisions related to transition planning. I have a few recommendations in this context:

A. If DOE intends to maintain the deletion, I recommend amending the new sentence as follows: “Beginning with the earlier of the first IEP to be in effect when the child turns 14 or enters 8th grade, or younger if determined appropriate by the IEP team, and updated annually thereafter, the IEP must include:”

B. As a practical matter, 8th grade students must decide to apply to Vo-Tech high schools very early in the school year. The following is an excerpt from the NCC Vo-Tech School District Website:

For 8th Grade Applicants:

Students are encouraged to submit completed applications to their school counselors by December 12th.

1. Applications submitted to counselors are then forwarded to the VoTech Office of Admissions by January 6th.

Applications that are directly submitted to the NCC Vo-Tech Office of Admissions (1417 Newport Road, Wilmington, DE 19804) should be received by January 6th.

Applications are reviewed by admissions counselors at Delcastle, Hodgson, Howard, and St. Georges VoTech high schools between January and March.

The VoTech Office of Admissions WILL CONTINUE to consider applications received any time during the school year or during the summer months; however, applications submitted by January 6 do receive primary consideration. Applications submitted after January 6 are considered on a case-by-case basis.

Many special education students would benefit from the enrollment in Vo-Tech schools and early transition planning is critical to ensure that students are aware of Vo-Tech options. By December 12 of 8th grade, they need to have a finished application. I highly recommend that the DOE be prescriptive in its standards in this context. Deleting references to “courses of study needed to assist the child in reaching these goals” and “plans to make application to ...career technical education programs” is not helpful. Since the graduation standards are being “tightened”, including the addition of 2 World Language credits, students and parents need to review options early to assess prospects for diploma eligibility and career options. Some variation on the deleted language should be preserved and embellished in the regulation.

Second, in §22.2.2, consider the following substitute for the proposed provision: “For a child with a disability beginning with the earlier of the first IEP to be in effect when the child turns 14 or

enters 8th grade, or younger if determined appropriate by the IEP Team”.

Third, in §27.3.3.2, I recommend inserting “or advanced practice nurse’s” after “physician’s”. As a practical matter, many individuals are now primarily treated by an advanced practice nurse rather than a traditional physician. Advanced practice nurses are authorized to perform independent acts of diagnosis and prescribe drugs. See Title 24 Del.C. §1902(b)(1). State law bars health insurers from denying benefits for eligible services when provided by an advanced practice nurse instead of a physician. See Title 18 Del.C. §2318. The attached December 28, 2010 News Journal article underscores that many individuals are primarily treated by advanced practice nurses.

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

17. DOE Prop. Children with Disabilities Part 924 LEA Eligibility Reg. [14 DE Reg. 607 (1/1/11)]

The Department of Education proposes to amend its special education regulation in the context of local educational agency eligibility. The summary recites as follows:

The proposed revisions to 14 DE Admin Code 924 are designed to continue the alignment of state and federal regulations addressing the education of children with disabilities and their families, and to establish the conditions under which school districts, charter schools, and other educational agencies may receive funding for the education of children with disabilities. 14 DE Admin Code 924 is also being revised to correct errata and some minor typographical errors.

At 608.

Unfortunately, there are no changes highlighted in the proposed regulations. The Registrar’s Office has published a Delaware Manual for Drafting Regulations. In pertinent part, it recites as follows:

2.4.3. Proposed Regulations:

- 2.4.3.1. Proposed changes to an existing regulation must be indicated as follows:
 - 2.4.3.1.1. Arial type shall indicate the text existing prior to the regulation being promulgated
 - 2.4.3.1.2. Underlined text must be used to indicate new text.
 - 2.4.3.1.3. Language which is ~~stricken~~ shall indicate text being deleted.
- 2.4.3.2. If a new regulation is being proposed, all language must be underlined.

I sent an email inquiry to the DOE on January 7 but had not received a response as of the date of submission of commentary to the SCPD. Since it is unclear what, if any, provisions are being amended, I am deferring commentary on the regulation. If a mix-up occurred with the Registrar’s Office, it is possible that the regulation will have to be republished.

Attachments

8g:legisreg/1111bils

F:pub/bjh/legis/2011p&l/111bils