

MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Recent Regulatory Initiatives

Date: August 11, 2011

I am providing my analysis of eleven (11) regulatory initiatives. I understand that, given the low number of regulations earmarked for review, the August 11 P&L Committee meeting has been cancelled. Given time constraints, my commentary should be considered tentative and non-exhaustive.

1. DLTCRP Final Alzheimer's Disease & Dementia Training Reg. [15 DE Reg. 192 (8/1/11)]

The SCPD and GACEC commented on the proposed version of this regulation in April. A copy of the GACEC's April 28 letter is attached for facilitated reference.

First, the Councils observed that the regulatory amendments in three (3) contexts (nursing facilities; assisted living facilities; group homes for persons with AIDS) omitted the statutory requirement that training be provided annually. DHSS agreed that this was an oversight and included the term "each year" in the three (3) sets of regulations.

Second, the Councils suggested that DHSS consider requiring training for personnel in both group homes for persons with mental illness and group homes for persons with developmental disabilities. DHSS declined to address training in these settings based on the rationale that they would infrequently house individuals with Alzheimer's or dementia.

Since the regulation is final, and DHSS addressed both concerns raised by the Councils, I recommend no further action.

2. DPH Final Alzheimer's Disease & Dementia Training Reg. [15 DE Reg. 220 (8/1/11)]

The SCPD and GACEC commented on the proposed version of this regulation in April. A copy of the GACEC's April 28 letter is attached for facilitated reference.

First, the Councils noted the omission of the statutory requirement of annual training in the adult day care facilities regulation. The Division added the language.

Second, the Councils identified some concerns with §5.8.12 in the skilled home health agency regulation. The Division agreed and attributed the errors to the Register of Regulations staff. It agreed to include a revised provision in the final regulation.

Since the regulation is final, and DPH addressed each Council concern, I recommend no further action.

3. DSS Final Child Care Subsidy Program In-home Care Regulation [15 DE Reg. 222 (8/1/11)]

The SCPD and GACEC commented on the proposed version of this regulation in June, 2011. The Councils endorsed the initiative. The Division of Social Services has now acknowledged the endorsements and adopted a final regulation which conforms to the proposed version. I recommend no further action.

4. DOE Final Career & Technical Education Program Regulation [15 DE Reg. 188 (8/1/11)]

After review, the SCPD and GACEC deferred formal commentary on the proposed version of this regulation in June, 2011. Instead, the GACEC forwarded the attached June 23 letter to the Department of Education requesting clarification of the rationale for the proposed changes since the proposed regulation omitted such information. The DOE responded through a July 19 email which recites as follows:

Prior to the amendments the regulation did not address block scheduling. Many of the high schools have moved to a block scheduling format where a course may not be held for the entire year, but rather fulfilled in a semester. Additionally, the amendments provide for the development of skilled and technical trade course pathways that are less than six credits. This provides flexibility to permit the future offering of skilled and technical pathways in all high schools.

The same clarification appears in the final regulation. The rationale makes sense and promotes flexibility in offering technical courses. Since the regulation is final, and the effect is positive, I recommend no further action.

5. DPH Pre-Hospital Advanced Care Directive Regulation [15 DE Reg. 211 (8/1/11)]

The SCPD and GACEC commented on the proposed version of this regulation in May, 2011. The Division of Public Health has now adopted a final regulation incorporating several amendments prompted by the commentary.

First, the Councils suggested substituting “advance” for “advanced” in references to health care directives to conform to the statute. DPH responded that it was its intention to adopt the

former term with one exception. Some references were therefore changed, including the definition of “Advance-~~d~~ Health Care Directive” in §1.0. There is a minor inconsistency in the heading of §5.0, *i.e.*, DPH intended to retain references to “Prehospital Advanced Care Directives” (p. 212) but revised this heading to read “Prehospital Advance Care Directive”. Compare §5.1 (using term “Prehospital Advanced Care Directive”).

Second, the Councils noted the repetition of a definition in §1.0. DPH responded that this error has been corrected in the final regulation.

Third, the Councils suggested that some words might have been omitted in the definition of “Health Care Decision”. Literally, there is a reference to “medication resuscitation” which makes no sense. Individuals are not resuscitated from a medication. In its response (p. 212), DPH inserts a comma so the reference is to “programs of medication, resuscitation; and;”. This makes sense. However, the actual text of the regulation omits the comma (p. 214) so it reads “medication resuscitation” .

Fourth, the Councils suggested inserting a reference to “permanent unconsciousness” to conform to the statute. The Division added the reference in the final regulation.

Fifth, the Councils recommended substituting “e.g.” for “i.e.” in §3.2. DPH agreed and effected the revision.

I recommend that the SCPD thank the Division for considering our comments while sharing the minor remaining errors identified above (“First” and “Third” paragraphs). Given the minor nature of the errors, the Division may wish to defer correction until the next overall revision of the regulation.

6. DOE Resident Advisor Credentials in DAP & Sterck Reg. [14 DE Reg. 1226 (5/1/11) (UPDATE)]

The SCPD and GACEC commented on the proposed version of this regulation in March, 2011. The most prominent concern raised by the Councils was the anemic credentials required to serve as a resident advisor in the statewide programs for autism and deaf/hard of hearing. A copy of the SCPD’s March 30 letter is attached. For example, there is no requirement that resident advisors at Sterck have any specialized communication or ASL familiarity whatsoever. Both federal special education law and the State Deaf or Hard of Hearing Bill of Rights contemplate the provision of qualified and trained personnel. The Department of Education declined to effect any amendment in this context in adopting a final regulation in June. The Councils then forwarded supplemental commentary to the DOE. A copy of the SCPD’s June 1 letter (co-signed by the Council for Deaf and Hard of Hearing Equality) is attached for facilitated reference.

The DOE has now responded to the Councils’ supplemental commentary through the attached July 19, 2011 correspondence. The DOE agreed to contact the Register of Regulations to review or correct some minor typographical or grammatical errors. However, it declined to modify its perspective on the lack of ASL capability to serve as a resident advisor at Sterck:

In regard to the comment related to the requirements for the Permit, the DOE requested input from the Delaware School for the Deaf Administrator regarding permits for resident advisors for the deaf/hard of hearing. The response was that requirements for these positions should not have a higher standard than a teacher of the deaf and hard of hearing. It was indicated that a preference may be given for individuals with ASL competency, but such a requirement would limit efforts to fully staff the residence.

The “weakness” in this rationale is that a teacher for “hard of hearing” students (e.g. using cochlear implants or FM amplification devices) may not need ASL. In contrast, students residing in a Sterck dorm will predominantly or exclusively communicate via ASL. They need to be able to communicate with supervising adults, i.e., resident advisors.

I recommend that the Councils solicit the written job description for a resident advisor position at Sterck to assess duties which would require the ability to communicate with students. I also recommend soliciting information on the percentage of Sterck residential students who communicate via ASL. Finally, I recommend sharing this information and Council concerns with Rep. Q. Johnson to assess the merits of a legislative response (e.g. amending the Deaf or Hard of Hearing Bill of Rights Act). See also the attached Title 14 Del.C. §206(d) for analogous statute requiring teachers of persons with visual impairments to be proficient in Braille.

7. DOE Proposed Educator Preparation Program Regulation [15 DE Reg. 146 (8/1/11)]

The Department of Education proposes to adopt a regulation authorizing the creation and implementation of an optional approach to alternate routes to teacher licensure and certification. The regulation authorizes, but does not require, the discretionary issuance of a DOE RFP to solicit applications from providers of teacher preparation programs.

The purpose of the regulation is described as follows:

The intent of the amended regulation is to provide additional opportunities for high-quality teacher preparation pipelines that will directly staff critical-need subject areas per the state’s current Alternative Routes to Teacher Licensure and Certification legislation. Additionally, such pipelines and their educators will be held accountable for performance by both the approved program and by the Department.

The amendments are expected to ensure that teachers in the most critical-need areas are better-equipped and highly-qualified to teach when coming through alternative-routes-to certification. Further, the criteria set forth in the amended regulation create an environment where teachers who participate in the new Department approved alternative-routes must demonstrate increased student achievement in order to obtain certification.

The amended regulation is also consistent with, and necessary to fulfill, the pledges that the Department made in its \$119 million Race to the Top application.

At 147.

In a nutshell, it appears that the regulation provides a method to target funds to address the need for teachers in critical-need subject areas. Parenthetically, the attached August 6, 2011 News

Journal article provides some support for the notion that there may be a national problem with the lack of production of teachers in critical-need contexts:

The NCTQ report concludes...we are overproducing elementary teachers. This is an important point- and one of the reasons that several years ago UD's Elementary Teacher Education faculty agreed that we would not prepare teachers the profession did not need. All of our elementary teacher education majors are required to select an additional certification or concentration in a high needs area such as special education, a middle school content area, or in urban education. This ensures our graduates are better able to handle the diverse classroom environment found in many of today's schools.

The regulation contemplates imposition of some rigorous standards on participating educators, including "intensive pre-service training, teacher evaluations conducted by school administrators, completion of coursework, and measures of teacher effectiveness based upon student performance data." At 154. There may be competing values inherent in this approach. On the one hand, adoption of more rigorous standards should theoretically result in more qualified teachers. On the other hand, adding disincentives to participate in alternate routes to teacher certification may deter promising candidates from pursuing certification. Weighing the competing considerations, I recommend endorsement.

8. VCAP Proposed Dental Payments Regulation [15 DE Reg. 175 (8/1/11)]

The Victim Compensation Assistance Program is proposing to adopt a regulation establishing payment standards for restorative dental services necessitated by a violent crime against the victim/patient. The proposed regulation is based on a template for medical and mental health payments previously adopted by the VCAP. See 14 DE Reg. 666 (January 1, 2011) (medical claims); and 14 DE Reg. 1082 (April 1, 2011) (mental health claims). That template incorporates language recommended by the DLP, including protections from balance billing of the victim and third parties. The Councils endorsed the medical and mental health claims regulations.

The current proposal is well written and conforms to the material provisions in the earlier regulations. I recommend endorsement.

9. Dept. Of Insurance Prop. Health Premium Consumer Comparison Reg [15 DE Reg. 164 (8/1/11)]

The Department of Insurance proposes to adopt a regulation requiring State-licensed health insurers to respond to a Department survey of rates/premiums on an annual basis. The Department will provide hypothetical profiles of individuals and coverage levels. The insurers will have to provide their rates for coverage applicable to the hypothetical individuals in a set format. The data will be published on the Web and consumers will be able to submit a request for a quote directly on the Web site. Non-compliance subjects the insurer to an administrative penalty (\$9.0).

Since the regulation would facilitate consumer informed choice, I recommend a strong endorsement subject to one caveat. Section 3.1 refers to "Insurers, Health Service Corporations and Managed Care Organizations". The references to "Health Service Corporations and Managed Care Organizations" may be redundant since the definition of "Insurer" in §2.0 includes health services

corporations and managed care organizations. The Department may wish to consider revising §3.1.

10. DMMA (Exempt) Respectful Language Regulation [15 DE Reg. 202 (August 1, 2011)]

The Division of Medicaid & Medical Assistance is revising many of its regulations to incorporate respectful and “people-first” language in implementation of H.B. No. 91. DMMA is issuing the regulations as final standards based on the APA exemption for standards effecting non-substantive changes to alter style or form. Therefore, comments have not been solicited. In general, the proposed revisions represent improved language. There are a few references that could be improved. For example, in §13760, DMMA should have changed the reference from “Waiver of the developmentally disabled” to “Waiver for individuals with a developmental disability”. The contexts that arguably could be improved are few and minor and would not warrant republication of the regulation. I recommend sending an informal communication to the Division endorsing its quick response to H.B. No. 91.

11. DMMA Draft PDN Provider Specific Policy

A. Background

In 2005 DHSS issued a comprehensive regulation addressing Medicaid coverage of private duty nursing (“PDN”) services. The SCPD, DDC, and GACEC submitted extensive comments which prompted several amendments. However, there remained some contexts of concern to the Councils, including weekly caps on PDN hours (8 hours for adults and 16 hours for children); and bar on “banking” or “carrying over” hours. In May of 2009, the DLP challenged the no-exceptions 8-hour cap on PDN on behalf of a twenty-nine year old with Duchenne muscular dystrophy with a peg feeding tube and tracheotomy with a primary diagnosis of ventilator dependent respiratory failure. A DMMA hearing officer upheld the no-exceptions 8-hour cap on PDN irrespective of need. The DLP appealed that decision to Superior Court. Consistent with the attached article, the application of such caps is a national problem which has prompted litigation in other states. A common scenario is an individuals receiving 16 hours of PDN under the children’s cap being threatened with institutionalization when reaching age 21 in states with no or reduced PDN for adults.

In August, 2009, Council and DLP representatives met with DHSS representatives to review concerns with limited access to PDN. An informal agreement was reached to interpret an existing regulation as authorizing an exception to the 8-hour PDN cap for adults:

5.3.3: An increase in hours may be approved if additional hours will avoid hospitalization or institutional placement as a cost effective measure. This will depend on the medical necessity, the amount of additional hours needed and the letter of medical necessity from the admitting physician.

This interpretation was an interim approach pending development of revised regulations. In practice, technologically dependent adult Medicaid beneficiaries are currently provided more than 8 hours of PDN if necessary to avoid institutionalization based on that regulation. Given the change in practice, the DLP withdrew its appeal of the adverse hearing officer decision. In the Fall of 2009, DMMA established a work group to undertake a comprehensive revision to its PDN standards.

After periodic SCPD reminders, DMMA shared the attached draft set of standards several months ago. I am now belatedly providing this critique of the draft standards.

B. Analysis

§§1.0 and 5.1: The “Overview” section includes a salutary provision requiring MCOs to provide PDN consistent with the policy. However, MCOs were historically responsible only for the first 28 hours of PDN per week. See 8 DE Reg. 1303, 1306, Section 1.0 (March 1, 2005). This limit is absent from the policy. Perhaps it has been superseded by changes in the DSHP. Moreover, §5.1 contemplates DSAAPD or DMMA nursing approval of PDN exclusively rather than an MCO nurse. The policy does not address MCO authorization of PDN. The current responsibility of MCOs should be clarified in the contexts of number of hours and authorization. In a similar context, the policy covers PDN covered under the E&D waiver. See §5.1.1.1. Normally, a waiver has its own utilization limits and standards. If the waiver standards differ from the draft policy, they will have to be reconciled to conform.

§§1.0 and 1.1.1: These sections convey inconsistent messages. On the one hand, §1.1.1 establishes a PDN cap of 16 hours for children under age 21. On the other hand, §1.0 recites that such limits are ignored if more services are medically necessary. Under the Medicaid program, all services must be medically necessary. This approach is confusing and will predictably lead to disparities in application of the policy. DMMA could consider the following alternative approaches. First, it could simply delete the 16-hour cap in §1.1.1. Second, since relatively few children will need more than 16 hours of PDN, consider the following:

- 1.1.1. Children under age 21 are eligible for up to sixteen hours of PDN daily. This presumptive limit is subject to exception based on either:
 - 1.1.1.1 meeting the criteria of §1.1.5;
 - 1.1.1.2 meeting the criteria of §5.2.3;
 - 1.1.1.3 meeting the criteria of 5.2.6; or
 - 1.1.1.4 based on compelling justification, securing the written approval of the Medicaid Director or designee.

The addition of §1.1.1.4 provides some additional flexibility to DMMA since compelling circumstances apart from institutionalization could arise (e.g. sudden, temporary, unexpected illness or injury of caregiver). The addition of §1.1.1.2 clarifies the interplay between §5.2.3 and this section.

§§1.1.2 and 5.2.3 and 5.2.6:

A. The 2009 hearing officer decision opined that the (currently renumbered) §1.1.5 did not apply to adults. It is therefore critical to clarify DMMA’s regulatory intention that §1.1.5 does authorize an exception to the 8-hour adult limit in §1.1.2.

B. It is important to clarify that §1.1.3 is an exception to §1.1.2.

C. The rationale for the exception in §5.2.3 would logically apply to both caregivers of children and adults. Therefore, §5.2.3 should be amended by substituting “individual” for “child”.

D. The rationale for the exception in §5.2.6 would also apply to adult day programs. Section 5.2.6 should be revised to include adults unable to attend a day program due to sickness, closure, or inclement weather.

Similar to the above recommended children’s standard, I recommend amending §1.1.2 as follows:

1.1.2. Adult Medicaid clients age 21 and over are eligible for up to eight hours of PDN daily. This presumptive limit is subject to exception based on either:

- 1.1.2.1 meeting the criteria of §1.1.3;
- 1.1.2.2 meeting the criteria of §1.1.5;
- 1.1.2.3 meeting the criteria of §5.2.3;
- 1.1.2.4 meeting the criteria of §5.2.6; or
- 1.1.2.5 based on compelling justification, securing the written approval of the Medicaid Director or designee.

§1.1.3.2: The SCPD may wish to consult a medical expert to assess the technical criteria in this subsection. The proposed DMMA policy is ostensibly “underinclusive” in the context of technology dependency and too strict in addressing tracheostomy needs. The attached Washington State policy, for example, includes consideration of “complex respiratory support” apart from a tracheotomy, including “application of respiratory vests” and “intermittent positive pressure breathing” which do not appear within the DMMA policy. Moreover, the DMMA policy requires that all 6 bullets under this subsection be met. Thus, if someone needed suctioning every hour (6th bullet) but only needed nebulizer treatments 3 times a day, the person would not qualify for more than 8 hours of PDN. Likewise, the DMMA policy does not address intravenous/parenteral administration of medications or nutritional substances on a continuing or frequent basis in contrast to the Washington State policy.

§1.1.5: The reference to “admitting” should be deleted. PDN is not provided within facilities. See §1.1.6.

§5.1.4: This subsection categorically precludes all “banking” or “carryover” of hours not used in one day. DHSS has been adopting more flexible standards in similar programs. For example, the DHSS Personal Attendant Services (PAS) program allows flexibility in use of hours within the same pay period. The attached PAS Service Specifications recite as follows:

4.11 The use of flexed hours within the same time period is permitted. No hours can be

“borrowed” or “advanced” in anticipation of paying them back through flexing at a later date. 4.12 Additional short term attendant services hours may be authorized for consumers if determined eligible by the DSAAPD Case Manager.

[emphasis supplied]. It would be preferable for the PDN standards to incorporate a similar approach.

In their 2005 comments on the previously numbered subsection, the Councils commented as follows:

(T)he regulations are unduly constrictive in the context of “carryover”. See Sections 5.1.5 and 5.2.9. The standards explicitly disallow carryover even to the next day. A completely rigid and inflexible system is simply not realistic and will result in hardship to families. Recognizing that a weekly schedule is developed at a minimum, consider the following alternative to Section 5.2.9:

DSS projects a sufficient number of hours per day. If the hours authorized are not used on a particular day, the hours do not generally carryover to the next day or weekend nor can the hours be “banked” to be used at a later time. Occasional variations of 3 hours or less within a week based on unexpected or extenuating circumstances may be acceptable.

8 DE Reg. 1303, 1305. Consistent with the above commentary, DMMA could revise the proposed §5.1.4 as follows:

5.1.4. PDN hours must be used for the period of time in which they are authorized. If the hours authorized are not used on a particular day, the hours do not generally carry over to the next day or weekend nor can the hours be “banked” to be used at a later time. Occasional variations of 3 hours or less within a week based on unexpected or extenuating circumstances may be approved.

§5.2.1: In the second sentence, I believe DMMA intended to insert the word “for” between “responsibility” and “the”. However, there is some “tension” between a requirement of a “capable” caregiver and the ADA. There may be caregivers who are elderly or insufficiently capable/sophisticated to provide technical or physical care. They may not be able to physically lift a Medicaid patient due to their own disability. However, they may have the wherewithal to supervise the provision of care. Query whether a no-exceptions policy of caregiver capacity may violate the “reasonable accommodations” provisions of the ADA.

§5.2.4: I recommend adding the following sentence: “The consent of the child’s parent or guardian is required to authorize school-related PDN.” Under the IDEA, schools cannot force parents to use public or private insurance to provide a FAPE and must obtain parental consent to access a child’s Medicaid. See attached OSEP Policy Letter to Dr. O. Spann, 20 IDELR 627 (September 10, 1993). There may be parent-school “conflict” situations in which DHSS or an MCO authorizes only a limited number of PDN hours and the school wishes to “take” a disproportionate share of the overall

approved hours. In the event of a disagreement, the parent/guardian's decision prevails over the school's wishes.

§5.2.5: Consistent with the discussion of §5.2.1 above, there may be circumstances in which a parent/caregiver is not capable of independently transporting a child to and from medical appointments. For example, there may be technology at home to assist the parent/caregiver in providing care which is not available in-transit. Alternatively, a parent may be capable of suctioning a stable child in bed but be unable to suction the same child in a moving vehicle jostling the passengers up and down and side to side. The last two sentences of this subsection are too rigid.

In conclusion, I recommend consulting a medical expert in connection with §1.1.3.2. Subject to revision based on the expert consultation, I recommend submitting the attached comments to DHSS, including its Secretary.

Attachments

8g:billreg/811bils
F:pub/bjh/legis/p&l2011/811bils