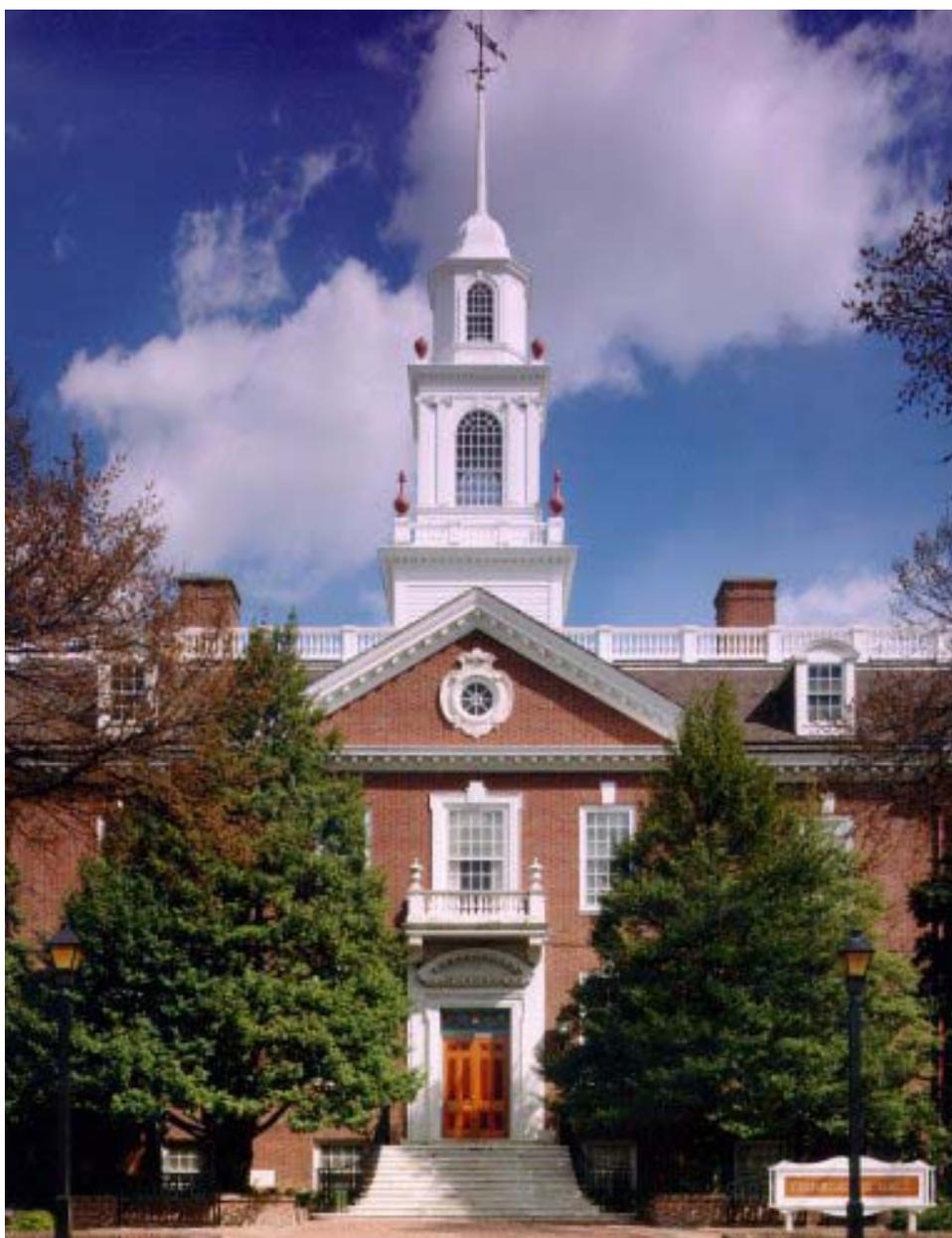

Delaware Register of Regulations

Issue Date: February 1, 2007

Volume 10 - Issue 8, Pages 1168 - 1342



IN THIS ISSUE:

Regulations:

Emergency

Proposed

Final

Governor:

Executive Orders

Appointments

General Notices

Calendar of Events &

Hearing Notices



Pursuant to 29 **Del.C.** Chapter 11, Subchapter III, this issue of the Register contains all documents required to be published, and received, on or before January 16 2007.

INFORMATION ABOUT THE DELAWARE REGISTER OF REGULATIONS

1169

DELAWARE REGISTER OF REGULATIONS

The *Delaware Register of Regulations* is an official State publication established by authority of 69 *Del. Laws*, c. 107 and is published on the first of each month throughout the year.

The *Delaware Register* will publish any regulations that are proposed to be adopted, amended or repealed and any emergency regulations promulgated.

The *Register* will also publish some or all of the following information:

- Governor's Executive Orders
- Governor's Appointments
- Agency Hearing and Meeting Notices
- Other documents considered to be in the public interest.

CITATION TO THE DELAWARE REGISTER

The *Delaware Register of Regulations* is cited by volume, issue, page number and date. An example would be:

9 **DE Reg.** 1036-1040 (01/01/06)

Refers to Volume 9, pages 1036-1040 of the *Delaware Register* issued on January 1, 2006.

SUBSCRIPTION INFORMATION

The cost of a yearly subscription (12 issues) for the *Delaware Register of Regulations* is \$135.00. Single copies are available at a cost of \$12.00 per issue, including postage. For more information contact the Division of Research at 302-744-4114 or 1-800-282-8545 in Delaware.

CITIZEN PARTICIPATION IN THE REGULATORY PROCESS

Delaware citizens and other interested parties may participate in the process by which administrative regulations are adopted, amended or repealed, and may initiate the process by which the validity and applicability of regulations is determined.

Under 29 **Del.C.** §10115 whenever an agency proposes to formulate, adopt, amend or repeal a regulation, it shall file notice and full text of such proposals, together with copies of the existing regulation being adopted, amended or repealed, with the Registrar for publication in the *Register of Regulations* pursuant to §1134 of this title. The notice shall describe the nature of the proceedings including a brief synopsis of the subject, substance, issues, possible terms of the agency action, a reference to the legal authority of the agency to act, and reference to any other regulations that may be impacted or affected by the proposal, and shall state the manner in which persons may present their views; if in writing, of the place to which and the final date by which such views may be submitted; or if at a public hearing, the date, time and place of the hearing. If a public hearing is to be held, such public hearing shall not be scheduled less than 20 days following publication of notice of the proposal in the *Register of Regulations*. If a public hearing will be held on the proposal, notice of the time, date, place and a summary of the nature of the proposal shall also be published in at least 2 Delaware newspapers of general circulation. The notice shall also be mailed to all persons who have made timely written requests of the agency for advance notice of its regulation-making proceedings.

INFORMATION ABOUT THE DELAWARE REGISTER OF REGULATIONS

The opportunity for public comment shall be held open for a minimum of 30 days after the proposal is published in the *Register of Regulations*. At the conclusion of all hearings and after receipt, within the time allowed, of all written materials, upon all the testimonial and written evidence and information submitted, together with summaries of the evidence and information by subordinates, the agency shall determine whether a regulation should be adopted, amended or repealed and shall issue its conclusion in an order which shall include: (1) A brief summary of the evidence and information submitted; (2) A brief summary of its findings of fact with respect to the evidence and information, except where a rule of procedure is being adopted or amended; (3) A decision to adopt, amend or repeal a regulation or to take no action and the decision shall be supported by its findings on the evidence and information received; (4) The exact text and citation of such regulation adopted, amended or repealed; (5) The effective date of the order; (6) Any other findings or conclusions required by the law under which the agency has authority to act; and (7) The signature of at least a quorum of the agency members.

The effective date of an order which adopts, amends or repeals a regulation shall be not less than 10 days from the date the order adopting, amending or repealing a regulation has been published in its final form in the *Register of Regulations*, unless such adoption, amendment or repeal qualifies as an emergency under §10119.

Any person aggrieved by and claiming the unlawfulness of any regulation may bring an action in the Court for declaratory relief.

No action of an agency with respect to the making or consideration of a proposed adoption, amendment or repeal of a regulation shall be subject to review until final agency action on the proposal has been taken. When any regulation is the subject of an enforcement action in the Court, the lawfulness of such regulation may be reviewed by the Court as a defense in the action.

Except as provided in the preceding section, no judicial review of a regulation is available unless a complaint therefor is filed in the Court within 30 days of the day the agency order with respect to the regulation was published in the *Register of Regulations*.

CLOSING DATES AND ISSUE DATES FOR THE DELAWARE REGISTER OF REGULATIONS

ISSUE DATE	CLOSING DATE	CLOSING TIME
March 1	February 15	4:30 p.m.
April 1	March 15	4:30 p.m.
May 1	April 16	4:30 p.m.
June 1	May 15	4:30 p.m.
July 1	June 15	4:30 p.m.

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TABLE OF CONTENTS

1171

Cumulative Tables.....	1173
------------------------	------

EMERGENCY

DEPARTMENT OF INSURANCE

1301 Arbitration of Health Insurance Claims and Internal Review Process of Medical Insurance Carriers	1180
1403 Health Maintenance Organizations [Formerly Regulation 58].....	1190

PROPOSED

DEPARTMENT OF EDUCATION

Office of the Secretary

502 Alignment of Local School District Curricula to the State Content Standards	1202
540 Driver Education	1205

Professional Standards Board

1501 Knowledge, Skills and Responsibility Based Salary Supplements for Educators.....	1208
1516 Standard Certificate	1213

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Division of Medicaid and Medical Assistance

DSSM 20320 Ownership of Real Property by Institutionalized Individuals, and 20330.3 Promissory Notes, Loans and Property Agreements	1216
DSSM 20330.7 US Savings Bonds	1219
DSSM 20910.1 Institutionalized Spouse	1220

Division of Public Health

4104 Conrad State 30/J-1 Visa Waiver Program.....	1221
---	------

DEPARTMENT OF INSURANCE

608 Automobile Insurance Coverage.....	1232
1301 Arbitration of Health Insurance Claims and Internal Review Process of Medical Insurance Carriers	1233
1403 Health Maintenance Organizations [Formerly Regulation 58].....	1249

DEPARTMENT OF NATURAL RESOURCES AND ENVIRONMENTAL CONTROL

Division of Air and Waste Management

1142 Specific Emission Control Requirements, Section 2.0 Control of NOx Emissions from Industrial Boilers and Process Heaters at Petroleum Refineries.....	1280
--	------

Division of Fish and Wildlife

3581 Spiny Dogfish; Closure of Fishery (Formerly Tidal Finfish Reg. 27).....	1285
--	------

DEPARTMENT OF STATE

Division of Professional Regulation

2000 Delaware Board of Occupational Therapy.....	1286
2700 Board of Professional Land Surveyors	1290
3500 Board of Examiners of Psychologists, Sections 5.0, 10.0 and 13.0	1295

FINAL

DEPARTMENT OF AGRICULTURE

Pesticides Section

601 Delaware Pesticide Rules and Regulations.....	1300
---	------

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Division of Medicaid and Medical Assistance

Attendant Services Program Section 1915(c).....	1301
DSSM 20400.9.1.1 Treatment of Special Needs Trusts.....	1302

TABLE OF CONTENTS

DEPARTMENT OF INSURANCE

704 Homeowners Premium Consumer Comparison	1304
1215 Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities ...	1306
1501 Medicare Supplement Insurance Minimum Standards	1307

DEPARTMENT OF JUSTICE

Division of Fraud and Consumer Protection

Debt Management Services	1308
--------------------------------	------

DEPARTMENT OF STATE

Division of Professional Regulation

1400 Board of Electrical Examiners	1329
--	------

GOVERNOR

Executive Order No. 94 Declaring Tuesday, January 2, 2007 A Legal Holiday In Remembrance Of Former President Gerald R. Ford	1331
Appointments	1332

GENERAL NOTICES

DEPARTMENT OF NATURAL RESOURCES AND ENVIRONMENTAL CONTROL

Division of Air and Waste Management

Delaware State Implementation Plan for Attainment of the 8-Hour Ozone National Ambient Air Quality Standard, Revision for Establishment of 2008 and 2009 Mobile Source Emission Budgets	1334
--	------

CALENDAR OF EVENTS/HEARING NOTICES

Delaware River Basin Commission , Public Hearing and Business Meeting	1336
Department of Education , Notice of Monthly Meeting	1336
Dept. of Health and Social Services , Notice of Public Comment Periods	
<i>Div. of Medicaid and Med. Assist.</i> ,	
DSSM 20320 Ownership of Real Property; DSSM 20330.3 Promissory Notes, and	
DSSM 20330.7 U.S. Savings Bonds	1336
DSSM 20910.1 Institutionalized Spouse.....	1337
<i>Div. of Public Health</i> , Notice of Public Comment Period	
4104 Conrad State 30/J-1 Visa Waiver Program.....	1337
Dept. of Insurance , Notice of Public Hearings	
608 Automobile Insurance Coverage.....	1337
1301 Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims	1338
1403 Managed Care Organizations	1338
DNREC , <i>Div. of Air and Waste Management</i> , Notice of Public Hearing.....	1339
<i>Div. of Air and Waste Management</i> , Notice of Public Hearing.....	1340
<i>Div. of Fish and Wildlife</i> , Notice of Public Hearing.....	1340
Dept. of State , <i>Div. of Professional Regulation</i> , Notice of Public Hearings	
Board of Occupational Therapy,	1341
Board of Professional Land Surveyors.....	1341
Board of Examiners of Psychologists,	1342

The table printed below lists the regulations that have been proposed, adopted, amended or repealed in the preceding issues of the current volume of the *Delaware Register of Regulations*.

The regulations are listed alphabetically by the promulgating agency, followed by a citation to that issue of the *Register* in which the regulation was published. Proposed regulations are designated with (Prop.); Final regulations are designated with (Final); Emergency regulations are designated with (Emer.); and regulations that have been repealed are designated with (Rep.).

COUNCIL ON POLICE TRAINING

Council on Police Training..... 10 **DE Reg.** 341 (Final)

DELAWARE MANUFACTURED HOME RELOCATION AUTHORITY

201 Delaware Manufactured Home Relocation Trust Fund Regulations 10 **DE Reg.** 928 (Prop.)

DELAWARE STATE FIRE PREVENTION COMMISSION

2006 Delaware State Fire Prevention Regulations..... 10 **DE Reg.** 342 (Final)

DEPARTMENT OF AGRICULTURE

Delaware Agriculture Lands Preservation Foundation

1301 Regulations Governing the Delaware Agricultural Forestlands Preservation
Program 10 **DE Reg.** 9 (Prop.)
10 **DE Reg.** 825 (Final)

Delaware Forest Service

402 State Forest Regulations 10 **DE Reg.** 88 (Final)

Harness Racing Commission

501 Harness Racing Rules and Regulations..... 10 **DE Reg.** 217 (Prop.)
10 **DE Reg.** 393 (Prop.)
10 **DE Reg.** 980 (Final)
Sections 3.0, 5.0 and 8.0..... 10 **DE Reg.** 931 (Prop.)
502 Delaware Standardbred Breeders Fund Regulations 10 **DE Reg.** 982 (Final)

Nutrient Management Commission

1201 Nutrient Management Certification Regulations 10 **DE Reg.** 411 (Prop.)
10 **DE Reg.** 1098 (Prop.)
1203 Mandatory Nutrient Management Plan Reporting Implementation
Regulations..... 10 **DE Reg.** 411 (Prop.)

Pesticides Management

601 Pesticide Rules and Regulations..... 10 **DE Reg.** 236 (Prop.)
10 **DE Reg.** 833 (Final)

Thoroughbred Racing Commission

1001 Thoroughbred Racing Rules and Regulations..... 10 **DE Reg.** 27 (Prop.)
10 **DE Reg.** 546 (Final)
10 **DE Reg.** 1086 (Prop.)

DEPARTMENT OF EDUCATION

Office of the Secretary

101 Delaware Student Testing Program..... 10 **DE Reg.** 245 (Prop.)
10 **DE Reg.** 676 (Final)
10 **DE Reg.** 1103 (Prop.)
103 Accountability for Schools, Districts and the State..... 10 **DE Reg.** 89 (Final)
201 District and School Shared Decision Making..... 10 **DE Reg.** 1140 (Final)
201 School Shared Decision Making Transition Planning Grants; 205 District
Shared Decision Making Transition Planning Grants; 210 Approval of
School Improvement Grants 10 **DE Reg.** 773 (Prop.)
10 **DE Reg.** 1140 (Final)

CUMULATIVE TABLES

247 Delaware Post Secondary Internship Program at the Washington Center (TWC) for Internships and Academic Seminars.....	10 DE Reg.	779 (Prop.)
		10 DE Reg. 1142 (Final)
284 Licensure and Certification of Public Education Employees in the Department.....	10 DE Reg.	600 (Prop.)
		10 DE Reg. 983 (Final)
290 Approval of Teacher Education Programs.....	10 DE Reg.	835 (Final)
292 Post Secondary Institutions and Degree Granting Institutions of Higher Education.....	10 DE Reg.	850 (Final)
314 Certification Administrative Principal or Assistant Principal Administrator of Adult and Adult Alternative Education	10 DE Reg.	613 (Prop.)
(Repealed).....	10 DE Reg.	984 (Final)
320 Certification Adult Education Teacher	10 DE Reg.	613 (Prop.)
(Repealed).....	10 DE Reg.	984 (Final)
371 Certification Teacher of the Hearing Impaired.....	10 DE Reg.	781 (Prop.)
372 Certification Administrative Support Personnel (Formerly Secretarial Personnel).....	10 DE Reg.	785 (Prop.)
		10 DE Reg. 1143 (Final)
398 Degree Granting Institutions of Higher Education	10 DE Reg.	417 (Prop.)
399 Approval of Teacher Education Programs	10 DE Reg.	428 (Prop.)
502 Alignment of Local School District Curricula to the State Content Standards...	10 DE Reg.	344 (Final)
503 Instructional Program Requirements	10 DE Reg.	615 (Prop.)
		10 DE Reg. 985 (Final)
505 High School Graduation Requirements and Diplomas.....	10 DE Reg.	30 (Prop.)
		10 DE Reg. 547 (Final)
745 Criminal Background Check for Public School Related Employment.....	10 DE Reg.	253 (Prop.)
		10 DE Reg. 684 (Final)
885 Safe Management and Disposal of Chemicals in the Delaware Public School System	10 DE Reg.	952 (Prop.)
910 Delaware General Educational Development (GED) Endorsement.....	10 DE Reg.	442 (Prop.)
		10 DE Reg. 862 (Final)
915 James H. Groves High School	10 DE Reg.	617 (Prop.)
		10 DE Reg. 988 (Final)
1001 Participation in Extra Curricular Activities.....	10 DE Reg.	1112 (Prop.)
1103 Standards for School Bus Chassis and Bodies for Buses Placed in Production on or after January 1, 2007.....	10 DE Reg.	258 (Prop.)
		10 DE Reg. 690 (Final)
Professional Standards Board		
360 Certification Early Childhood Special Education Teacher.....	10 DE Reg.	1114 (Prop.)
1511 Issuance and Renewal of Continuing License.....	10 DE Reg.	97 (Final)
1521 Standard Certificate Agriculture Teacher.....	10 DE Reg.	100 (Final)
1522 Standard Certificate Business Education Teacher.....	10 DE Reg.	100 (Final)
1525 Standard Certificate English Teacher.....	10 DE Reg.	100 (Final)
1526 Standard Certificate English to Speakers of Other Languages.....	10 DE Reg.	34 (Prop.)
		10 DE Reg. 208 (Errata)
		10 DE Reg. 388 (Errata)
		10 DE Reg. 995 (Final)
1527 Endorsement English to Speakers of Other Languages (ESOL) Teacher	10 DE Reg.	38 (Prop.)
(Repealed).....	10 DE Reg.	999 (Final)
1528 Standard Certificate World Language Teacher Comprehensive.....	10 DE Reg.	100 (Final)
1534 Standard Certificate Mathematics Teacher Secondary.....	10 DE Reg.	100 (Final)
1537 Standard Certificate Bilingual Teacher K to 12	10 DE Reg.	39 (Prop.)
		10 DE Reg. 693 (Final)
1539 Standard Certificate Social Studies Teacher Secondary.....	10 DE Reg.	100 (Final)
1540 Standard Certificate Science Teacher Secondary.....	10 DE Reg.	100 (Final)
1541 Standard Certificate Mathematics Teacher Middle Level.....	10 DE Reg.	100 (Final)

1542 Standard Certificate Science Teacher Middle Level.....	10	DE Reg.	100 (Final)
1543 Standard Certificate Art Teacher Comprehensive.....	10	DE Reg.	100 (Final)
1548 Standard Certificate Music Teacher Comprehensive.....	10	DE Reg.	100 (Final)
1551 Standard Certificate Physical Education Teacher Comprehensive.....	10	DE Reg.	100 (Final)
1554 Standard Certificate Reading Specialist.....	10	DE Reg.	100 (Final)
1556 Standard Certificate Elementary Teacher (Grades K-6).....	10	DE Reg.	100 (Final)
1558 Standard Certificate Bilingual Teacher (Spanish) Primary and Middle.....	10	DE Reg.	44 (Prop.)
			10 DE Reg. 695 (Final)
1561 Standard Certificate Teacher Exceptional Children Special Education Elementary, Repeal.....	10	DE Reg.	788 (Prop.)
1562 Standard Certificate Teacher Exceptional Children Special Education Secondary.....	10	DE Reg.	790 (Prop.)
1570 Standard Certificate Early Childhood Teacher Special Education	10	DE Reg.	45 (Prop.)
			10 DE Reg. 211 (Errata)
			10 DE Reg. 696 (Final)
1572 Standard Certificate Teacher of Students Who Are Deaf or Hard of Hearing	10	DE Reg.	1144 (Final)
1579 Standard Certificate Teacher of the Visually Impaired	10	DE Reg.	623 (Prop.)
			10 DE Reg. 1147 (Final)

DEPARTMENT OF FINANCE

Division of Revenue

Abandoned or Unclaimed Property Voluntary Disclosure Agreement and Audit Programs.....	10	DE Reg.	1502 (Prop.)
			10 DE Reg. 699 (Final)
301 Publication of Tax Information.....	10	DE Reg.	794 (Prop.)
			10 DE Reg. 1116 (Prop.)

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Division of Long Term Care Residents Protection

Nursing Home Survey Process.....	10	DE Reg.	6 (Emer.)
----------------------------------	----	----------------	-----------

Division of Medicaid and Medical Assistance

Assisted Living Medicaid 1915(c) Waiver	10	DE Reg.	56 (Prop.)
			10 DE Reg. 1001 (Final)
Attendant Services Program.....	10	DE Reg.	954 (Prop.)
Diamond State Health Plan 1115 Demonstration Waiver.....	10	DE Reg.	55 (Prop.)
			10 DE Reg. 549 (Final)
Title XIX Medicaid State Plan, Supplement 3 to Attachment 2.6-A, Pg. 1, Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered Under Medicaid.....	10	DE Reg.	52 (Prop.)
			10 DE Reg. 703 (Final)
Title XIX, Transfer of Assets for Less Than Fair Market Value Made on or After February 8, 2006.....	10	DE Reg.	955 (Prop.)
Title XXI Delaware Healthy Children State Program.....	10	DE Reg.	444 (Prop.)
			10 DE Reg. 865 (Final)

DSSM:

20310 Long Term Care Medicaid	10	DE Reg.	553 (Final)
20330.4, Retirement Funds.....	10	DE Reg.	795 (Prop.)
20330.4.1, Annuities.....	10	DE Reg.	798 (Prop.)
20350 Transfer of Assets	10	DE Reg.	955 (Prop.)
20350.4, Multiple Transfers.....	10	DE Reg.	1117 (Prop.)
20350.10, Long Term Care Medicaid, Exceptions to the Transfer of Assets ...	10	DE Reg.	50 (Prop.)
			10 DE Reg. 558 (Final)
20400.5 Irrevocable Trusts.....	10	DE Reg.	955 (Prop.)
20400.9.1.1 Treatment of Special Needs Trusts	10	DE Reg.	965 (Prop.)
20910.1 Long Term Care, Institutionalized Spouse	10	DE Reg.	701 (Final)
20950 Initial Eligibility Determinations.....	10	DE Reg.	283 (Prop.)

CUMULATIVE TABLES

20950 Initial Eligibility Determinations.....	10 DE Reg. 702 (Final)
20970 Fair Hearings.....	10 DE Reg. 283 (Prop.)
	10 DE Reg. 702 (Final)
30000 Delaware Prescription Assistance Program.....	10 DE Reg. 446 (Prop.)
	10 DE Reg. 866 (Final)
50100 Services Provided by the Chronic Renal Disease Program.....	10 DE Reg. 347 (Final)

Division of Social Services

DSSM:

3000 Temporary Assistance for Needy Families (TANF).....	10 DE Reg. 286 (Prop.)
3001 Definitions.....	10 DE Reg. 283 (Prop.)
	10 DE Reg. 706 (Final)
3006 TANF Employment and Training Program.....	10 DE Reg. 283 (Prop.)
	10 DE Reg. 706 (Final)
3008 Eligibility of Certain Minors.....	10 DE Reg. 283 (Prop.)
	10 DE Reg. 706 (Final)
3012 School Attendance.....	10 DE Reg. 283 (Prop.)
	10 DE Reg. 706 (Final)
3031 Work for Your Welfare.....	10 DE Reg. 283 (Prop.)
	10 DE Reg. 706 (Final)
9013.1 Household Definition.....	10 DE Reg. 626 (Prop.)
	10 DE Reg. 1003 (Final)
9085 Reporting Changes.....	10 DE Reg. 57 (Prop.)
	10 DE Reg. 560 (Final)
11000 Child Care Subsidy Program.....	10 DE Reg. 447 (Prop.)
	10 DE Reg. 564 (Final)
	10 DE Reg. 1007 (Final)
15120 Financial Eligibility.....	10 DE Reg. 143 (Final)
16230.1.2 Self-Employment Income.....	10 DE Reg. 143 (Final)
17300.3.2 Self-Employment Income.....	10 DE Reg. 143 (Final)
20210.16 Self Employment.....	10 DE Reg. 143 (Final)
20620.2 Necessary Medical Care Expenses.....	10 DE Reg. 52 (Prop.)
	10 DE Reg. 703 (Final)
20995.1 Post-Eligibility Deductions.....	10 DE Reg. 52 (Prop.)
	10 DE Reg. 703 (Final)

DEPARTMENT OF INSURANCE

504 Continuing Education for Insurance Agents, Brokers, Surplus Lines Brokers and Consultants.....	10 DE Reg. 60 (Prop.)
	10 DE Reg. 734 (Final)
610 Automobile Premium Consumer Comparison.....	10 DE Reg. 62 (Prop.)
	10 DE Reg. 566 (Final)
704 Homeowners Premium Consumer Comparison.....	10 DE Reg. 967 (Prop.)
1215 Recognition of Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities.....	10 DE Reg. 968 (Prop.)
1501 Medicare Supplement Insurance Minimum Standards.....	10 DE Reg. 802 (Prop.)

DEPARTMENT OF JUSTICE

Division of Fraud and Consumer Protection

Debt Management Services.....	10 DE Reg. 804 (Prop.)
Identity Theft Passports.....	10 DE Reg. 811 (Prop.)
	10 DE Reg. 1151 (Final)

DEPARTMENT OF LABOR

Division of Employment and Training

106 Apprenticeship and Training Regulations.....	10 DE Reg. 64 (Prop.)
(to be transferred to the Division of Industrial Affairs)	10 DE Reg. 458 (Prop.)

Division of Industrial Affairs

106 Apprenticeship and Training Regulations 10 **DE Reg.** 1021(Final)

DEPARTMENT OF NATURAL RESOURCES AND ENVIRONMENTAL CONTROL

Office of the Secretary

106 Environmental Standards for Eligible Energy Resources..... 10 **DE Reg.** 350 (Final)

Division of Air and Waste Management

1113 Open Burning..... 10 **DE Reg.** 1118 (Prop.)

1124 Control of Volatile Organic Compound Emissions, Section 46..... 10 **DE Reg.** 813 (Prop.)

10 **DE Reg.** 867 (Final)

1141 Limiting Emissions of VOC from Consumer and Commercial Products 10 **DE Reg.** 465 (Prop.)

10 **DE Reg.** 868 (Final)

1146 Electric Generating Unit (EGU) Multi-Pollutant Regulations 10 **DE Reg.** 508 (Prop.)

10 **DE Reg.** 1022 (Final)

1302 Regulations Governing Hazardous Waste..... 10 **DE Reg.** 353 (Final)

Division of Fish and Wildlife

3200 Horseshoe Crabs (3203, 3207, 3210, 3211 and 3214; 3215)..... 10 **DE Reg.** 519 (Prop.)

10 **DE Reg.** 1029 (Final)

3536 Fish Pot Requirements (Formerly Tidal Finfish Reg. 24)..... 10 **DE Reg.** 629 (Prop.)

10 **DE Reg.** 1035 (Final)

3700 Shellfish Regulations (3711, 3712 and 3755) 10 **DE Reg.** 522 (Prop.)

10 **DE Reg.** 1034 (Final)

Division of Soil and Water

5101 Sediment and Stormwater Regulations (Exempt from A.P.A.)..... 10 **DE Reg.** 735 (Final)

5102 Regulation Governing Beach Protection and the Use of Beaches..... 10 **DE Reg.** 870 (Final)

Division of Water Resources

7402 Shellfish Sanitation Regulations 10 **DE Reg.** 145 (Final)

Watershed Assessment Section, Total Maximum Daily Loads (TMDLs)

7412 Chester River Watershed..... 10 **DE Reg.** 1041 (Final)

7413 Choptank River Watershed..... 10 **DE Reg.** 1041 (Final)

7414 Marshyhope Creek Watershed..... 10 **DE Reg.** 1041 (Final)

7415 Pocomoke River Watershed..... 10 **DE Reg.** 1041 (Final)

7416 Army Creek Watershed..... 10 **DE Reg.** 305 (Prop.)

10 **DE Reg.** 1042 (Final)

7417 Blackbird Creek Watershed..... 10 **DE Reg.** 1037 (Final)

7418 Broadkill River Watershed..... 10 **DE Reg.** 1038 (Final)

7419 Cedar Creek Watershed..... 10 **DE Reg.** 1038 (Final)

7420 Dragon Run Creek Watershed..... 10 **DE Reg.** 305 (Prop.)

10 **DE Reg.** 1042 (Final)

7421 Leipsic River Watershed..... 10 **DE Reg.** 1037 (Final)

7422 Little Creek Watershed..... 10 **DE Reg.** 1037 (Final)

7423 Mispillion River Watershed 10 **DE Reg.** 1038 (Final)

7424 Red Lion Creek Watershed..... 10 **DE Reg.** 305 (Prop.)

10 **DE Reg.** 1042 (Final)

7425 Smyrna River Watershed 10 **DE Reg.** 1037 (Final)

7426 St. Jones River Watershed 10 **DE Reg.** 1037 (Final)

7427 Appoquinimink River Watershed, Bacteria for, (formerly 7403)..... 10 **DE Reg.** 524 (Prop.)

10 **DE Reg.** 1039 (Final)

7428 Murderkill River Watershed..... 10 **DE Reg.** 524 (Prop.)

10 **DE Reg.** 1041 (Final)

7429 Inland Bays Drainage Basin 10 **DE Reg.** 524 (Prop.)

10 **DE Reg.** 1041 (Final)

7430 Chesapeake Bay Drainage Basin..... 10 **DE Reg.** 524 (Prop.)

10 **DE Reg.** 1041 (Final)

DEPARTMENT OF SAFETY AND HOMELAND SECURITY**Board of Examiners of Private Investigators and Private Security Agencies**

1300 Board of Examiners of Private Investigators and Private Security Agencies 10 DE Reg. 971 (Prop.)

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES**Division of Family Services**

101 Day Care Centers..... 10 DE Reg. 308 (Prop.)

DEPARTMENT OF STATE**Division of Professional Regulation**

200 Board of Landscape Architects..... 10 DE Reg. 1124 (Prop.)

500 Board of Podiatry..... 10 DE Reg. 309 (Prop.)

700 Board of Chiropractic..... 10 DE Reg. 1153 (Final)

10 DE Reg. 146 (Final)

10 DE Reg. 1126 (Prop.)

1400 Board of Electrical Examiners 10 DE Reg. 631 (Prop.)

1770 Respiratory Care Advisory Council..... 10 DE Reg. 354 (Final)

1800 Board of Plumbing Examiners 10 DE Reg. 65 (Prop.)

1900 Board of Nursing..... 10 DE Reg. 1127 (Prop.)

2500 Board of Pharmacy..... 10 DE Reg. 311 (Prop.)

Section 8.0, Requirements for Obtaining a Permit to Distribute Drugs

on a Wholesale Basis 10 DE Reg. 972 (Prop.)

Section 9.0, Hospital Pharmacy..... 10 DE Reg. 821 (Prop.)

2600 Examining Board of Physical Therapists..... 10 DE Reg. 318 (Prop.)

10 DE Reg. 741 (Final)

3000 Board of Professional Counselors of Mental Health and Chemical
Dependency Professionals 10 DE Reg. 67 (Prop.)

Section 6.0, Renewal of Licensure..... 10 DE Reg. 871 (Final)

Sections 1.0 through 9.0, Reorganized and Renumbered..... 10 DE Reg. 872 (Final)

3100 Delaware Board of Funeral Services..... 10 DE Reg. 528 (Prop.)

10 DE Reg. 1154 (Final)

3300 Board of Veterinary Medicine 10 DE Reg. 531 (Prop.)

10 DE Reg. 884 (Final)

10 DE Reg. 1137 (Prop.)

3600 Board of Registration of Geologists..... 10 DE Reg. 68 (Prop.)

10 DE Reg. 567 (Final)

3900 Board of Clinical Social Work Examiners..... 10 DE Reg. 323 (Prop.)

10 DE Reg. 886 (Final)

4400 Delaware Manufactured Home Installation Board..... 10 DE Reg. 331 (Prop.)

10 DE Reg. 634 (Prop.)

10 DE Reg. 1156 (Final)

5300 State Board of Massage and Bodywork 10 DE Reg. 71 (Prop.)

10 DE Reg. 575 (Final)

Office of the State Bank Commissioner1101 Election to be Treated for Tax Purposes as a "Subsidiary Corporation" of a
DE Chartered Banking Organization or Trust Company, National Bank having
its Principle Office in Delaware, or Out-of-State Bank that Operates Resulting
Branch in Delaware..... 10 DE Reg. 643 (Prop.)

1109 Instructions for Calculation of Employment Tax Credits 10 DE Reg. 643 (Prop.)

1113 Election by a Subsidiary Corporation of a Banking Organization or Trust
Company to be Taxed in Accordance with Chapter 19 of Title 30 10 DE Reg. 643 (Prop.)

1114 Alternative Franchise Tax..... 10 DE Reg. 643 (Prop.)

Public Service CommissionRegulation Docket No. 49, Creation of a Competitive Market for
Retail Electric Supply Service 10 DE Reg. 664 (Prop.)

10 DE Reg. 1160 (Final)

Regulation Docket No. 50, Proposed Adoption of “Electric Service Reliability and Quality Standards”	10 DE Reg. 74 (Prop.)
	10 DE Reg. 576 (Final)
Regulation Docket No. 56, Proposed Adoption of “Rules to Implement Renewable Energy Portfolio Standards”	10 DE Reg. 151 (Final)

DEPARTMENT OF TRANSPORTATION**Division of Planning and Policy**

Development Related Improvements Requiring New Rights-of-Way.....	10 DE Reg. 892 (Final)
Utilities Manual Regulations.....	10 DE Reg. 1139 (Prop.)

Office of Motor Fuel Tax Administration

2401 Regulations for the Office of Retail Gasoline Sales	10 DE Reg. 542 (Prop.)
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GOVERNOR’S OFFICE**Executive Orders:**

Executive Order No. 87, Establishing The State Employees’ Charitable Campaign	10 DE Reg. 158
Executive Order No. 88, Recognizing and Establishing the Delaware Science and Technology Council.....	10 DE Reg. 366
Executive Order No. 89, Creating the Governor’s Consortium on Hispanic Issues.	10 DE Reg. 578
Executive Order No. 90, Establishing The Recycling Public Advisory Council.	10 DE Reg. 903
Executive Order No. 91, Amending Executive Order No. 84.....	10 DE Reg. 1067
Executive Order No. 92, Authorizing The Establishment Of A Special Fund To Assist Any Delaware National Guard Member Or Delaware-Based Reservist Who May Be Ordered To Active Duty.....	10 DE Reg. 1067
Executive Order No. 93, Amendment to Executive Order Number Eighty-Eight Regarding the Delaware Science and Technology Council.....	10 DE Reg. 1162

Appointments:

.....	10 DE Reg. 368
	10 DE Reg. 905

Symbol Key

Arial type indicates the text existing prior to the regulation being promulgated. Underlined text indicates new text. Language which is ~~stricken~~ through indicates text being deleted.

Emergency Regulations

Under 29 **Del.C.** §10119 an agency may promulgate a regulatory change as an Emergency under the following conditions:

§ 10119. Emergency regulations.

If an agency determines that an imminent peril to the public health, safety or welfare requires the adoption, amendment or repeal of a regulation with less than the notice required by § 10115, the following rules shall apply:

- (1) The agency may proceed to act without prior notice or hearing or upon any abbreviated notice and hearing that it finds practicable;
- (2) The order adopting, amending or repealing a regulation shall state, in writing, the reasons for the agency's determination that such emergency action is necessary;
- (3) The order effecting such action may be effective for a period of not longer than 120 days and may be renewed once for a period not exceeding 60 days;
- (4) When such an order is issued without any of the public procedures otherwise required or authorized by this chapter, the agency shall state as part of the order that it will receive, consider and respond to petitions by any interested person for the reconsideration or revision thereof; and
- (5) The agency shall submit a copy of the emergency order to the Registrar for publication in the next issue of the Register of Regulations. (60 Del. Laws, c. 585, § 1; 62 Del. Laws, c. 301, § 2; 71 Del. Laws, c. 48, § 10.)

DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Sections 311 and 332 (18 **Del.C.** §§ 311, 332 and 6401 *et seq.*)

18 **DE Admin. Code** 1301

EMERGENCY ORDER

Pursuant to 29 **Del.C.** §10119, it is necessary to promulgate an amendment to Regulation 1301 relating to Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims.

REASONS FOR EMERGENCY ACTION

A. On July 6, 2006, Senate Bill 295 was enacted as 75 **Del. Laws** 362 transferring regulatory oversight of managed care organizations to the Department of Insurance ("Department") from the Department of Health and Social Services. Sections 3 and 6 of the act provided for full implementation of the act by January 6, 2007.

B. The transfer of regulatory authority created the need for substantial revisions to existing regulations currently in force as well as the need to make significant changes to the case handling system for medical insurance claims, reviews and arbitrations within the Department.

C. The Department was not able to complete the process of amending the existing regulations, including the requirement to meet the publication and public notice provisions of the Delaware Administrative Procedures Act within the prescribed time limit.

D. If an emergency regulation is not adopted, there is the potential that numerous claims will not be able to have the statutory review allowed by Delaware law and that Delaware citizens will be at risk of having benefits delayed or denied because there is no regulatory guidance to fill the gap as a result of the transfer of regulatory authority to the Department.

E. The Department has completed the work necessary to submit the proposed amended regulations for public comment and by issuing this emergency order will permit a timely transition for the review of medical

claims during the time required for public comment on the proposed regulatory amendments.

DECISION AND ORDER

1. Regulation 1301 as currently promulgated is rescinded and the attached amended version of Regulation 1301 is substituted in lieu thereof effective January 6, 2007.
2. This order shall be effective until April 30, 2007 or until the attached amendment to Regulation 1301 is adopted pursuant to the Delaware Administrative Procedures Act whichever shall first occur. The Department will receive, consider and respond to petitions by any interested person for the reconsideration or revision of the emergency regulation.
3. The Department gives public notice of the proposed amendment to Regulation 1301 as required by 29 **Del.C.** §10115 as follows:

PUBLIC NOTICE OF PROPOSED DEPARTMENT OF INSURANCE REGULATION RELATING TO INTERNAL REVIEW, ARBITRATION AND INDEPENDENT UTILIZATION REVIEW OF HEALTH INSURANCE CLAIMS

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of proposed amendments to Department of Insurance Regulation 1301 relating to Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims. The docket number for this proposed regulation is 356.

The Department of Insurance proposes to amend Regulation 1301 by rescinding the current regulation and substituting in lieu thereof revised provisions for the review and arbitration of health insurance claims. As a result of the enactment of Senate Bill 295 on July 6, 2006, it became necessary to re-promulgate Regulation 1301 to provide for the review of claims from managed care organizations formerly under the regulatory authority of the Department of Health and Social Services. The Delaware Code authority for the change is 18 **Del.C.** §§ 311, 332 and 6401 et seq. The text can also be viewed at the Delaware Insurance Commissioner's website at www.delawareinsurance.gov and clicking on the link for "Proposed Regulations."

The Department of Insurance will hold a public hearing on the proposed changes on February 26, 2007 at 10:00 a.m. in the Consumer Services hearing room, 841 Silver Lake Blvd., Dover, DE 19904. Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed amendment. Any written submission in response to this notice and relevant to the proposed change must be received by the Department of Insurance no later than 4:30 p.m., Tuesday, March 6, 2007 by delivering said comments to Deputy Attorney General Michael J. Rich, c/o Delaware Department of Insurance, 841 Silver Lake Boulevard, Dover, DE 19904, or sent by fax to 302.739.5566 or emailed to michael.rich@state.de.us.

4. Since the wording of the attached emergency regulation is identical to the wording the Department intends to adopt as a final regulation, public comment on the emergency regulation shall be deemed to be public comment on the proposed regulation as would otherwise be permitted under 29 **Del.C.** § 10115.

IT IS SO ORDERED this 8th day of January, 2007

Matthew Denn, Insurance Commissioner

1301 Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims

1.0 Purpose and Statutory Authority

1.1 The purpose of this Regulation is to implement 18 **Del.C.** §§332, 6416 and 6417 which require health insurance carriers to establish a procedure for internal review of a carrier's adverse coverage determination

and which require the Delaware Insurance Department to establish and administer procedures for arbitration and independent utilization review upon completion of the carrier's internal review process. This Regulation also implements 18 Del.C. §§3349 and 3565, which require the Delaware Insurance Department to establish and administer procedures for arbitration of disputes between health insurance carriers and non-network providers of emergency care services. This Regulation is promulgated pursuant to 18 Del.C. §§ 311, 332, 3349, 3565 and 6408 and 29 Del.C., Ch. 101. This Regulation should not be construed to create any cause of action not otherwise existing at law.

2.0 Definitions

2.1 The following words and terms, when used in this regulation, should have the following meaning unless the context clearly indicates otherwise:

"Adverse determination" means a decision by a carrier to deny (in whole or in part), reduce, limit or terminate health insurance benefits.

"Appeal" means a request for external review of a carrier's final coverage decision through the Independent Health Care Appeals Program.

"Appropriateness of services" means an appeal classification for adverse determinations that are made based on identification of treatment as cosmetic, investigational, experimental or not an appropriate or preferred treatment method or setting for the condition for which treatment is sought.

"Authorized representative" means an individual who a covered person willingly acknowledges to represent his interests during the internal review process, arbitration and/or an appeal through the Independent Health Care Appeals Program, including but not limited to a provider to whom a covered person has assigned the right to collect sums due from a carrier for health care services rendered by the provider to the covered person. A carrier may require the covered person to submit written verification of his consent to be represented. If a covered person has been determined by a physician to be incapable of assigning the right of representation, the covered person may be represented by a family member or a legal representative.

"Carrier" means any entity that provides health insurance in this State. Carrier includes an insurance company, health service corporation, managed care organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. Carrier also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health insurance.

"Covered person" means an individual and/or family who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with a carrier, pursuant to which the carrier provides health insurance for such person or persons.

"Department" means the Delaware Insurance Department.

"Emergency care provider" means a provider of emergency care services.

"Emergency care services" means those services identified in 18 Del.C. §§3349(c) and 3565(c) including:

A. Any covered service providing for the transportation of a patient to a hospital emergency facility for an emergency medical condition including air and sea ambulances so long as medical necessity criteria are met; and

B. Facility and professional providers of emergency medical services in an approved emergency care facility.

"Emergency medical condition" shall have the meaning assigned to it by 18 Del.C. §§3349(d) and 3565(d).

"Final coverage decision" means the decision by a carrier at the conclusion of its internal review process upholding, modifying or reversing its adverse determination.

"Grievance" means a request by a covered person or his authorized representative that a carrier review an adverse determination by means of the carrier's internal review process.

"Health care services" means any services or supplies included in the furnishing to any individual of medical or dental care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any individual of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury, disability or disease.

"Health insurance" means a plan or policy issued by a carrier for the payment for, provision of, or reimbursement for health care services.

"Independent Health Care Appeals Program ("IHCAP")" means a program administered by the

Department that provides for an external review by an Independent Utilization Review Organization of a carrier's final coverage decision based on medical necessity or appropriateness of services.

"Independent Utilization Review Organization ("IURO")" means an entity that conducts independent external reviews of a carrier's final coverage decisions resulting in a denial, termination, or other limitation of covered health care services based on medical necessity or appropriateness of services.

"Internal review process ("IRP")" means a procedure established by a carrier for internal review of an adverse determination.

"Medical necessity" means providing of health care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

- A. In accordance with generally accepted standards of medical practice;
- B. Consistent with the symptoms or treatment of the condition; and
- C. Not solely for anyone's convenience.

"Network carrier" is a carrier that has a written participation agreement with an emergency care provider to pay for emergency care services in Delaware.

"Network emergency care provider" is an emergency care provider who has a written participation agreement with the carrier to provide emergency care services or governing payment of emergency care services in Delaware as of the date those services were provided. All other emergency care providers shall be considered non-network emergency care providers.

"Provider" means an individual or entity, including without limitation, a licensed physician, a licensed nurse, a licensed physician assistant and a licensed nurse practitioner, a licensed diagnostic facility, a licensed clinical facility, and a licensed hospital, who or which provides health care services in this State.

3.0 Minimum Requirements for an Internal Review Process (IRP)

In addition to the requirements set forth in 18 Del.C. §332, the following provisions shall govern the internal review process of all carriers offering health insurance in Delaware:

3.1 All written procedures and forms utilized by a carrier shall be readable and understandable by a person of average intelligence and education. All such documents shall meet the following criteria:

3.1.1 The type size shall not be smaller than 11 point;

3.1.2 The type style selection shall be at the discretion of the carrier but shall be of a type that is clear and legible;

3.1.3 Captions or headings shall be designed to stand out clearly;

3.1.4 White space separating subjects or sections should be distinct;

3.1.5 There must be included a table of contents sufficient to guide and assist the covered person or his authorized representative;

3.1.6 Where appropriate, definitions shall be included, shall be sufficient to clearly apply to the usage intended, and shall not conflict with the definitions contained in this regulation.

3.1.7 The forms shall be written in everyday, conversational language to the extent possible to preserve the legal meaning.

3.1.8 Short familiar words shall be used and sentences shall be kept as short and simple as possible.

3.2 The carrier shall provide all forms relating to grievances, appeals, arbitration or other procedures relating to IRP as examples along with the written notice of IRP provided to the covered person.

3.3 Written notice.

3.3.1 For any IRP not previously approved by the Department, the carrier shall provide written notice of the IRP to all covered persons within 30 days of approval by the Department.

3.3.2 The carrier shall provide the annual notice required by 18 Del.C. §332(c)(1) to covered persons either upon the policy renewal date, open enrollment date, or a set date for all covered persons, in the carrier's discretion.

3.3.3 For every new policy issued after the Department's approval of the IRP, the carrier shall provide covered persons with a copy of the IRP at the time, or prior to the time, the carrier sends identification cards, member handbooks or similar member materials to newly covered persons.

3.3.4 When a covered person's dependents reside in the same household as the covered person, a single notice to the principal covered person shall be sufficient under this section.

3.4 Under circumstances where an oral or written grievance may not contain sufficient information and the carrier requests additional information, such request shall not be burdensome or require such information as the carrier might reasonably be expected to obtain through its normal claims process.

4.0 Mediation Services

At the time a carrier provides to a covered person written notice of a carrier's final coverage decision, if the decision does not authorize payment of the claim in its entirety, the carrier shall provide the covered person with a written notice of mediation services offered by the Department. Such notice may be separate from or a part of the written notice of the carrier's decision. Any notice provided to a covered person shall, at a minimum, contain the following language:

"You have the right to seek review of a claim denial through the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to review of this decision. You can contact the Delaware Insurance Department for information about claim denial review or mediation by calling the Consumer Services Division at 800-282-8611 or 302-739-4251. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the review or mediation process. All requests for review through procedures established by the Delaware Insurance Department must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final."

5.0 Options for External Review of a Carrier's Final Coverage Decision

5.1 A covered person or his authorized representative may request review of a carrier's final coverage decision through the Department by filing either a Petition for Arbitration or filing an appeal through the Independent Health Care Appeals Program, depending on the basis for the carrier's final coverage decision as set forth herein.

5.2 Arbitration (sections 6.0 and 7.0 of this regulation). Except for claims exempt from arbitration by law or regulation, every carrier, provider, network emergency care provider and non-network emergency care provider as defined in this regulation shall submit to arbitration the following:

5.2.1 covered claims arising from the provision of emergency care services under 18 Del.C. §§3349 and 3565; and

5.2.2 final coverage decisions denying claims based on grounds other than medical necessity or appropriateness of services.

5.3 Independent Health Care Appeals Program (sections 8.0 through 11.0 of this regulation). A carrier shall submit all requests for review of final coverage decisions denying claims based, in whole or in part, on medical necessity or appropriateness of services ("appeals") to the Independent Health Care Appeals Program ("IHCAP").

5.3.1 For cases in which a carrier's final coverage decision should be reviewed through arbitration and through IHCAP, or where there is an ambiguity as to whether review should be through arbitration or through IHCAP, review shall be conducted through IHCAP.

5.4 Exemption from Arbitration. 18 Del.C. §§3349(b) and 3565(b) shall not apply to health insurance policies exempt from state regulation under federal law or regulation. On a quarterly basis, each carrier shall provide a list of non-exempt plan numbers to the Department. The Department shall maintain a public register of such non-exempt plan numbers. The placement of a non-exempt plan number on the register shall constitute a rebuttable presumption that such non-exempt plan number is subject to the provisions of this regulation. A carrier that clearly identifies whether a plan is either exempt or non-exempt on the face of an identification or membership card shall not be required to comply with the provisions of this sub-section but only with respect to the plans for which such identification or membership cards display the group status.

5.5 The provisions of this regulation shall not apply to Medicaid or any other health insurance program where the review of coverage determinations is otherwise regulated by the provisions of other state or federal laws or regulations.

6.0 Arbitration Procedure

6.1 Petition for Arbitration

6.1.1 A covered person or his authorized representative may request review of a carrier's final coverage decision through arbitration by delivering a Petition for Arbitration to the Department so that it is received by the Department no later than 60 days after the covered person's receipt of written notice of the carrier's final coverage decision.

6.1.2 A covered person or his authorized representative must deliver to the Department an original and three copies of the Petition for Arbitration.

6.1.3 At the time of delivering the Petition for Arbitration to the Department, a covered person or his authorized representative must also:

6.1.3.1 send a copy of the Petition to the carrier by certified mail, return receipt requested;

6.1.3.2 deliver to the Department a Proof of Service confirming that a copy of the Petition has been sent to the carrier by certified mail, return receipt requested; and

6.1.3.3 deliver to the Department a non-refundable \$75.00 filing fee.

6.1.4 The Department may refuse to accept any Petition that is not timely filed or does not otherwise meet the criteria for arbitration. If the subject of the Petition is appropriate for review through IHCAP, the Department shall advise the covered person or his authorized representative of the procedure to obtain IHCAP review. If the subject of the Petition is appropriate for IHCAP review, the Petition for Arbitration will be treated as an IHCAP appeal for purposes of determining whether the IHCAP appeal is timely filed in accordance with section 8.1 of this regulation.

6.2 Response to Petition for Arbitration

6.2.1 Within 20 days of receipt of the Petition, the carrier must deliver to the Department an original and three copies of a Response with supporting documents or other evidence attached.

6.2.2 At the time of delivering the Response to the Department, the carrier must also:

6.2.2.1 send a copy of the Response and supporting documentation to the covered person or his authorized representative by first class U.S. mail, postage prepaid; and

6.2.2.2 deliver to the Department a Proof of Service confirming that a copy of the Response was mailed to the covered person or his authorized representative.

6.2.3 The Department may return any non-conforming Response to the carrier.

6.2.4 If the carrier fails to deliver a Response to the Department in a timely fashion, the Department, after verifying proper service, and with written notice to the parties, may assign the matter to the next scheduled Arbitrator for summary disposition.

6.2.4.1 The Arbitrator may determine the matter in the nature of a default judgment after establishing that the Petition is properly supported and was properly served on the carrier.

6.2.4.2 The Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than seven days after notice of the default judgment.

6.3 Summary Dismissal of Petition by the Department

6.3.1 If the Department determines that the subject of the Petition is not appropriate for arbitration or IHCAP or is meritless on its face, the Department may summarily dismiss the Petition and provide notice of such dismissal to the parties.

6.4 Appointment of Arbitrator

6.4.1 Upon receipt of a proper Response, the Department shall assign an Arbitrator who shall schedule the matter for a hearing so that the Arbitrator can render a written decision within 45 days of the delivery to the Department of the Petition for Arbitration.

6.4.2 The Arbitrator shall be of suitable background and experience to decide the matter in dispute and shall not be affiliated with any of the parties or with the provider whose service is at issue in the dispute.

6.5 Arbitration Hearing

6.5.1 The Arbitrator shall give notice of the arbitration hearing date to the parties at least 10 days prior to the hearing. The parties are not required to appear and may rely on the papers delivered to the Department.

6.5.2 The arbitration hearing is to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence and to answer questions by the Arbitrator.

6.5.3 If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross-examination or other response by the opposing party.

EMERGENCY REGULATIONS

6.5.4 The Delaware Uniform Rules of Evidence will be used for general guidance but will not be strictly applied.

6.5.5 Because the testimony may involve evidence relating to personal health information that is confidential and protected by state or federal laws from public disclosure, the arbitration hearing shall be closed unless otherwise agreed by the parties.

6.5.6 The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter.

6.5.7 The Arbitrator is to consider the matter based on the submissions of the parties and information otherwise obtained by the Arbitrator in accordance with this regulation. The Arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least five days notice, except claims of a continuing nature that are set out in the filed papers.

6.6 Arbitrator's Written Decision.

6.6.1 The Arbitrator shall render his decision and mail a copy of the decision to the parties within 45 days of the filing of the Petition.

6.6.2 The Arbitrator's decision is binding upon the carrier except as provided in 18 Del.C. §332(g).

6.7 Arbitration Costs.

6.7.1 In arbitrations commenced under 18 Del.C. §332, the carrier shall pay the costs and fees of arbitration which exceed the non-refundable filing fee of \$75.00 required to commence arbitration.

6.7.2 In arbitrations commenced under 18 Del.C. §§3349 or 3565, the non-prevailing party(ies) shall pay the costs and fees of arbitration which exceed the non-refundable filing fee of \$75.00 required to commence arbitration.

7.0 Special Provisions Applicable to Arbitration Pursuant to 18 Del. C. §§3349 and 3565

7.1 In any arbitration pursuant to 18 Del.C. §§3349 or 3565, the Arbitrator shall, at a minimum, receive evidence relating to the following items:

7.1.1 The highest amount of money paid by the carrier to any emergency care provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

7.1.2 The lowest amount of money paid by the carrier to any emergency care provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

7.1.3 The highest amount of money received by the non-network emergency care provider from any carrier for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

7.1.4 The lowest amount of money received by the non-network emergency care provider from any carrier for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

7.1.5 The number of times during the preceding twelve months that the carrier experienced a dispute or disagreement with respect to the payment for the particular service in a comparable medical facility where the service was provided, and the outcome of such disputes or disagreements.

7.2 The information specified in section 7.1 of this regulation and provided to the Arbitrator shall presumptively be considered trade secret or confidential financial information under the Delaware Freedom of Information Act and shall not be disclosed to or available at any time to any person, firm or entity not involved in the arbitration.

7.3 The Arbitrator shall consider the following guidelines as a basis for determining the rate or charge for a disputed service unless the evidence adduced at arbitration requires a determination on a different basis:

7.3.1 *Payments for emergency care services with CPT codes.* A carrier shall pay non-network emergency care providers an amount equal to the lesser of the non-network emergency care provider billed fee for such service or the highest negotiated rate between the carrier and any network provider for the service based on the appropriate CPT code until such time as the non-network provider becomes a network provider pursuant to a written participation agreement. Thereafter payments will be based on the new negotiated rates.

7.3.2 *Payments for emergency care services without CPT codes.* For emergency care services

that do not have a CPT code or other identifiable code number, a carrier shall pay non-network emergency care providers the lesser of the non-network emergency care provider billed fee, or the highest negotiated network rate received by the non-network provider from any carrier for the performance of the same service. When and if the non-network provider becomes a network provider, payments will be based on the negotiated rate.

7.3.3 Changes in the membership of a provider group will not affect the remaining group member(s) insofar as the application of this section to payments for emergency care services. In the absence of a contract provision to the contrary, a physician's existing network status and payment rights shall not be transferable to that physician's new group or practice.

8.0 IHCAP Procedure

8.1 A covered person or his authorized representative may request review of a final coverage decision based on medical necessity or appropriateness of services by filing an appeal with the carrier within 60 days of receipt of the final coverage decision.

8.2 Upon receipt of an appeal, the carrier shall transmit the appeal electronically or by facsimile to the Department as soon as possible, but within no more than three business days, and shall send a hard copy of the request to the Department by mail.

8.3 Within five calendar days of receipt of an appeal, the Department shall assign an approved, impartial Independent Utilization Review Organization to review the final coverage decision and shall notify the carrier.

8.4 The assigned IURO shall, within five calendar days of assignment, notify the covered person or his authorized representative in writing by certified or registered mail that the appeal has been accepted for external review.

8.4.1 The notice shall include a provision stating that the covered person or his authorized representative may submit additional written information and supporting documentation that the IURO shall consider when conducting the external review.

8.4.2 The covered person or his authorized representative shall submit such written documentation to the IURO within seven calendar days following the date of receipt of the notice.

8.4.3 Upon receipt of any information submitted by the covered person or his authorized representative, the assigned IURO shall as soon as possible, but within no more than two business days, forward the information to the carrier.

8.4.4 The IURO must accept additional documentation submitted by the carrier in response to additional written information and supporting documentation from the covered person or his authorized representative.

8.5 Within seven calendar days after the receipt of the notification required in section 8.3, the carrier shall provide to the assigned IURO the documents and any information considered in making the final coverage decision.

8.5.1 If the carrier fails to submit documentation and information or fails to participate within the time specified, the assigned IURO may terminate the external review and make a decision, with the approval of the Department, to reverse the final coverage decision.

8.6 The external review may be terminated if the carrier decides to reverse its final coverage decision and provide coverage or payment for the health care service that is the subject of the appeal.

8.6.1 Immediately upon making the decision to reverse its final coverage decision, the carrier shall notify the covered person or his authorized representative, the assigned IURO, and the Department in writing of its decision. The assigned IURO shall terminate the external review upon receipt of the written notice from the carrier.

8.7 Within 45 days after the IURO's receipt of an appeal, the assigned IURO shall provide written notice of its decision to uphold or reverse the final coverage decision to the covered person or his authorized representative, the carrier and the Department, which notice shall include the following information:

8.7.1 the qualifications of the members of the review panel;

8.7.2 a general description of the reason for the request for external review;

8.7.3 the date the IURO received the assignment from the Department to conduct the external review;

8.7.4 the date(s) the external review was conducted;

8.7.5 the date of its decision;

8.7.6 the principal reason(s) for its decision; and

8.7.7 references to the evidence or documentation, including practice guidelines and clinical review criteria, considered in reaching its decision.

8.8 The decision of the IURO is binding upon the carrier except as provided in 18 Del.C. §6416(b).

9.0 Expedited IHCAP Procedure

9.1 A covered person or his authorized representative may request an expedited appeal at the time the carrier issues its final coverage decision if the covered person suffers from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition.

9.2 At the time the carrier receives request for an expedited appeal, the carrier shall immediately transmit the appeal electronically or by facsimile to the Department and shall send a hard copy to the Department by mail.

9.3 If the Department determines that the review meets the criteria for expedited review, the Department shall assign an approved, impartial IURO to conduct the external review and shall notify the carrier.

9.4 At the time the carrier receives the notification of the assigned IURO, the carrier shall provide or transmit all necessary documents and information considered in making its final coverage decision to the assigned IURO electronically, by telephone, by facsimile or any other available expeditious method.

9.5 As expeditiously as the covered person's medical condition permits or circumstances require, but in no event more than 72 hours after the IURO's receipt of the expedited appeal, the IURO shall make a decision to uphold or reverse the final coverage decision and immediately notify the covered person or his authorized representative, the carrier, and the Department of the decision.

9.6 Within two calendar days of the immediate notification, the assigned IURO shall provide written confirmation of its decision to the covered person or his authorized representative, the carrier, and the Department.

9.7 The decision of the IURO is binding upon the carrier except as provided in 18 Del.C. §6416(b).

10.0 Refusal or Dismissal of IHCAP Appeal

10.1 The Department may refuse to accept any appeal that is not timely filed or does not otherwise meet the criteria for IHCAP review. If the subject of the appeal is appropriate for arbitration, the Department shall advise the covered person or his authorized representative of the arbitration procedure. If the subject of the appeal is appropriate for arbitration, the appeal shall be treated as a Petition for Arbitration for purposes of determining whether the Petition is timely filed in accordance with section 6.1.1 of this regulation.

10.2 Carrier's motion to dismiss an IHCAP appeal.

10.2.1 A carrier may move to dismiss an IHCAP appeal if the carrier believes:

10.2.1.1 the appeal concerns a benefit that is the subject of an express written exclusion from the covered person's health insurance;

10.2.1.2 the appeal is appropriate for arbitration; or

10.2.1.3 the appeal should be dismissed because it is inappropriate for IHCAP review as explained in a sworn statement by an officer of the carrier.

10.2.2 The carrier's motion to dismiss must be made in writing at the time the carrier transmits the appeal to the Department and must include any necessary supporting documentation.

10.2.3 The Department shall review the appeal and motion for dismissal and may, in its discretion:

10.2.3.1 dismiss the appeal and notify the covered person or his authorized representative in writing that the appeal is inappropriate for the IHCAP; or

10.2.3.2 appoint an IURO to conduct a full external review.

11.0 IHCAP Costs

11.1 All costs for IHCAP review by an IURO, whether the review is preliminary, or partially or fully completed, shall be borne by the carrier.

11.2 The carrier shall reimburse the Department for the cost of the IHCAP review within 90 calendar days of receipt of the decision by the IURO or within 90 days of termination of review by the IURO by other means.

12.0 Approval of Independent Utilization Review Organizations

12.1 The Department shall approve IUROs eligible to be assigned to conduct IHCAP reviews as provided in 18 Del.C. §6417(a).

12.2 An IURO seeking approval to conduct IHCAP reviews shall submit an application to the Department that includes the information required by 18 Del.C. §§6417(c)(1), 6417(c)(2), 6417(c)(4) and 6417(c)(4)(d).

12.3 The Department shall maintain a current list of approved IUROs.

13.0 Carrier Recordkeeping and Reporting Requirements

13.1 A carrier shall maintain written or electronic records documenting all grievances, Petitions for Arbitration and appeals for IHCAP review including, at a minimum, the following information:

13.1.1 For each grievance:

13.1.1.1 the date received;

13.1.1.2 name and plan identification number of the covered person on whose behalf the grievance was filed;

13.1.1.3 a general description of the reason for the grievance; and

13.1.1.4 the date and description of the final coverage decision.

13.1.2 For each Petition for Arbitration:

13.1.2.1 the date the Petition was filed;

13.1.2.2 name and plan identification number of the covered person on whose behalf the Petition was filed;

13.1.2.3 a general description of the reason for the Petition; and

13.1.2.4 date and description of the Arbitrator's decision or other disposition of the

Petition.

13.1.3 For each appeal for IHCAP review:

13.1.3.1 the date received;

13.1.3.2 name and plan identification number of the covered person on whose behalf the appeal was filed;

13.1.3.3 a general description of the reason for the appeal; and

13.1.3.4 date and description of the IURO's decision or other disposition of the

appeal.

13.2 A carrier shall file with its annual report to the Department the following information:

13.2.1 The total number grievances filed.

13.2.2 The total number of Petitions for Arbitration filed, with a breakdown showing:

13.2.2.1 the total number of final coverage decisions upheld through arbitration;

13.2.2.2 the total number of final coverage decisions reversed through arbitration.

13.2.3 The total number of IHCAP appeals filed, with a breakdown showing:

13.2.3.1 the total number of final coverage decisions upheld through IHCAP; and

13.2.3.2 the total number of final coverage decisions reversed through IHCAP.

13.3 A carrier shall make available to the Department upon request any of the information specified in the foregoing sections 13.1 and 13.2, and other information regarding its internal review process including but not limited to the written IRP procedures and forms the carrier distributes to covered persons.

14.0 Non-Retaliation

14.1 A carrier shall not disenroll, terminate or in any way penalize a covered person who exercises his rights to file a grievance, Petition for Arbitration or appeal for IHCAP review solely on the basis of such filing.

14.2 A carrier shall not terminate or in any way penalize a provider with whom it has a contractual relationship and who exercises, on behalf of a covered person, the right to file a grievance, Petition for Arbitration or appeal for IHCAP review solely on the basis of such filing.

15.0 Confidentiality of Health Information

15.1 Nothing in this Regulation shall supersede any federal or state law or regulation governing the privacy of health information.

16.0 Effective Date

16.1 This regulation shall become effective on April 11, 2007. Pursuant to the order of the

EMERGENCY REGULATIONS

Commissioner dated January 8, 2007, any claim filed for review or arbitration after January 8, shall be governed by this regulation. Any claim filed for review or arbitration prior to January 8, 2007 under the version of this regulation adopted February 15, 2002 and not resolved prior to January 8, 2007 shall be governed by the February 15, 2002 version of this regulation.

DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Sections 311 and 332 (18 **Del.C.** §§ 311 and 6401 *et seq.*)

18 DE Admin. Code 1403

EMERGENCY ORDER

Pursuant to 29 **Del.C.** §10119, it is necessary to promulgate an amendment to Regulation 1403 relating to Managed Care Organizations.

REASONS FOR EMERGENCY ACTION

A. On July 6, 2006, Senate Bill 295 was enacted as 75 **Del. Laws** 362 transferring regulatory oversight of managed care organizations to the Department of Insurance ("Department") from the Department of Health and Social Services. Sections 3 and 6 of the act provided for full implementation of the act by January 6, 2007.

B. The transfer of regulatory authority created the need for substantial revisions to existing regulations currently in force as well as the need to make significant changes to the case handling system for medical insurance claims, reviews and arbitrations within the Department.

C. The Department was not able to complete the process of amending the existing regulations, including the requirement to meet the publication and public notice provisions of the Delaware Administrative Procedures Act within the prescribed time limit.

D. If an emergency regulation is not adopted, there is the potential that numerous claims will not be able to have the statutory review allowed by Delaware law, that there would be a void in the regulatory provisions governing the operation of managed care organizations and that Delaware citizens will be at risk of having benefits delayed or denied because there is no regulatory guidance to fill the gap as a result of the transfer of regulatory authority to the Department.

E. The Department has completed the work necessary to submit the proposed amended regulations for public comment and by issuing this emergency order will permit a timely transition for the review of medical claims during the time required for public comment on the proposed regulatory amendments.

DECISION AND ORDER

1. Regulation 1403 as currently promulgated is rescinded and the attached amended version of Regulation 1403 is substituted in lieu thereof effective January 6, 2007.

2. This order shall be effective until April 30, 2007 or until the attached amendment to Regulation 1403 is adopted pursuant to the Delaware Administrative Procedures Act whichever shall first occur. The Department will receive, consider and respond to petitions by any interested person for the reconsideration or revision of the emergency regulation.

3. The Department gives public notice of the proposed amendment to Regulation 1403 as required by 29 **Del.C.** §10115 as follows:

PUBLIC NOTICE OF PROPOSED DEPARTMENT OF INSURANCE REGULATION RELATING TO MANAGED CARE ORGANIZATIONS

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of proposed Department of Insurance Regulation 1403 relating to Managed Care Organizations. The docket number for this proposed regulation is 357.

The Department of Insurance proposes to amend Regulation 1403 by rescinding the current regulation and substituting in lieu thereof revised provisions relating to the regulation of Managed Care Organizations. As a result of the enactment of Senate Bill 295 on July 6, 2006, it became necessary to re-promulgate Regulation 1403 to provide for the regulation of managed care organizations formerly under the regulatory authority of the Department of Health and Social Services. The Delaware Code authority for the change is 18 Del. C. §§ 311 and 6401 et seq. The text can also be viewed at the Delaware Insurance Commissioner's website at www.delawareinsurance.gov and clicking on the link for "Proposed Regulations."

The Department of Insurance will hold a public hearing on the proposed changes on February 26, 2007 at 10:00 a.m. in the Consumer Services hearing room, 841 Silver Lake Blvd., Dover, DE 19904. Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed amendment. Any written submission in response to this notice and relevant to the proposed change must be received by the Department of Insurance no later than 4:30 p.m., Tuesday, March 6, 2007 by delivering said comments to Deputy Attorney General Michael J. Rich, c/o Delaware Department of Insurance, 841 Silver Lake Boulevard, Dover, DE 19904, or sent by fax to 302.739.5566 or emailed to michael.rich@state.de.us.

4. Since the wording of the attached emergency regulation is identical to the wording the Department intends to adopt as a final regulation, public comment on the emergency regulation shall be deemed to be public comment on the proposed regulation as would otherwise be permitted under 29 Del. C. § 10115

IT IS SO ORDERED this 8th day of January, 2007

Matthew Denn, Insurance Commissioner

1403 Health Maintenance Organizations [Formerly Regulation 58]

1.0 Purpose and Statutory Authority

1.1 The purpose of this Regulation is to implement 18 Del.C. Ch. 64, as amended effective July 6, 2006, which transferred regulatory authority over Managed Care Organizations from the Department of Health and Social Services to the Department of Insurance. This Regulation is promulgated pursuant to 18 Del.C. §6408 and 29 Del.C. Ch. 101.

2.0 Definitions

The following words and terms, when used in this regulation, should have the following meaning unless the context clearly indicates otherwise:

"Adverse determination" means a decision by an MCO to deny (in whole or in part), reduce, limit or terminate benefits under a health care contract.

"Appeal" means a request for external review of an MCO's determination resulting in a denial, termination or other limitations of covered health services based on medical necessity or appropriateness of services

"Appropriateness of services" means an appeal classification for adverse determinations that are made based on identification of treatment as cosmetic, investigational, experimental or not an appropriate or preferred treatment method or setting for the condition for which treatment is sought.

"Balance billing" means a health care provider's demand that a patient pay a greater amount for a given service than the amount the individual's insurer, managed care organization, or health service corporation has paid or will pay for the service.

"Basic Health Services" means a range of health care services, including at least the following:

EMERGENCY REGULATIONS

A. Physician services, including consultant and referral services, by a physician licensed by the State of Delaware;

B. At least 365 days of inpatient hospital services;

C. Medically necessary emergency health services;

D. Diagnostic laboratory services;

E. Diagnostic and therapeutic radiological services;

F. Preventive health services; and

G. Emergency out-of-area and out-of-network coverage.

“Carrier” means any entity that provides health insurance in this State. Carrier includes an insurance company, health service corporation, managed care organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. Carrier also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health insurance.

“Certificate of Authority” means the authorization by the Department to operate the MCO. This certificate shall be deemed to be a license to operate such an organization.

“Chief Executive Officer” means the individual employed to manage and direct the activities of the MCO.

“Covered health services” means services that are included in the enrollee’s health care contract with the carrier.

“Covered Person”: see “Enrollee.”

“Department” means the Delaware Department of Insurance.

“Emergency care” means health care items or services furnished or required to evaluate or treat an emergency medical condition.

“Emergency medical condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the health of the individual afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

B. Serious impairment to bodily functions;

C. Serious impairment or dysfunction of any bodily organ or part; or

D. Serious disfigurement of such person.

“Enrollee” means an individual and/or family who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into with the MCO, under which the MCO assumes the responsibility to provide to such person(s) coverage for basic health services and such supplemental health services as are enumerated in the health care contract.

“Geographically accessible” means a location no greater than 30 miles or 40 minutes driving time from 90% of enrollees within MCO’s geographic service area.

“Geographic service area” means the stated primary geographical area served by an MCO. The primary area served shall be a radius of not more than 20 miles or more than 30 minutes driving time from a primary care office operated or contracted by the MCO.

“Grievance” means a request by an enrollee that an MCO review an adverse determination by means of the MCO’s internal review process.

“Health care contract” means any agreement between an MCO and an enrollee or group plan which sets forth the services to be supplied to the enrollee in exchange for payments made by the enrollee or group plan.

“Health care professional” means an individual engaged in the delivery of health care services as licensed or certified by the State of Delaware.

“Health care services” means any services included in the furnishing to any individual of medical or dental care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury or physical disability.

“Independent Health Care Appeals Program” means a program administered by the Department which provides for a review by an Independent Utilization Review Organization.

“Independent Utilization Review Organization (IURO)” means an entity that conducts independent external reviews of a carrier’s determinations resulting in a denial, termination, or other limitation of covered health

care services based on medical necessity or appropriateness of services.

“Intermediary” means a person authorized to negotiate and execute provider contracts with MCOs on behalf of health care providers or on behalf of a network.

“Internal review process” means a procedure established by an MCO for internal review of an adverse determination.

“Level 1 trauma center” means a regional resource trauma center that has the capability of providing leadership and comprehensive, definitive care for every aspect of injury from prevention through rehabilitation.

“Level 2 trauma center” means a regional trauma center with the capability to provide initial care for all trauma patients. Most patients would continue to be cared for in this center; there may be some complex cases which would require transfer for the depth of services of a regional Level 1 or specialty center.

“Managed Care Organization (MCO)” means a public or private organization, organized under the laws of any state, which:

A. Provides or otherwise makes available to enrollees health care services, including at least the basic health services defined in this section;

B. Is primarily compensated (except for co-payment) for the provision of basic health services to enrollee on a predetermined periodic rate basis; and

C. Provides physician services.
An MCO may also arrange for health care services on a prepayment or other financial basis.

“Medical necessity” means providing of covered health services or products that a prudent physician would provide to a patient for the purpose of diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:

A. In accordance with generally accepted standards of medical practice;

B. Consistent with the symptoms or treatment of the condition; and

C. Not solely for anyone’s convenience.

“Network” means the participating providers delivering services to enrollees.

“Office” means any facility where enrollees receive primary care or other health care services.

“Out of area coverage” means health care services provided outside the MCO’s geographic service areas with appropriate limitations and guidelines acceptable to the Department. At a minimum, such coverage must include emergency care.

“Participating provider” means a provider who, under a contract with the MCO or with its contractor or sub contractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the MCO.

“Premium” means payment(s) called for in the health care contract which must be:

A. Paid or arranged for by, or on behalf of, the enrollee before health care services are rendered by the MCO;

B. Paid on a periodic basis without regard to the date on which health care services are rendered; and

C. With respect to an individual enrollee, are fixed without regard to frequency, extent or cost of health services actually furnished.

“Primary care physician (PCP)” means a participating physician chosen by the enrollee and designated by the MCO to supervise, coordinate, or provide initial care or continuing care to an enrollee, and who may be required by the MCO to initiate a referral for specialty care and maintain supervision of health care services rendered to the enrollee.

“Provider” means a health care professional or facility.

“Staff Model MCO” means an MCO in which physicians are employed directly by the MCO or in which the MCO directly operates facilities which provide health care services to enrollees.

“Tertiary services” means health care services provided for the intensive treatment of critically ill patients who require extraordinary care on a concentrated basis in special diagnostic categories (e.g., burns, cardiovascular, neonatal, pediatric, oncology, transplants, etc.).

“Utilization review” means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, efficacy, and/or efficiency of, health care services, procedures or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

EMERGENCY REGULATIONS

3.0 Certificate of Authority

3.1 Each application for a Certificate of Authority as a Managed Care Organization shall be made on Form No. H-1 entitled "Application for Certificate of Authority as a Managed Care Organization" (Exhibit A to this regulation). The application shall be accompanied by the following:

3.1.1 The information specified in 18 Del.C. §6404(a):

3.1.2 Evidence of accreditation by a nationally-recognized managed care accrediting organization such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or similar organization:

3.1.3 For Staff Model MCOs, evidence that the MCO satisfies the physical plant requirements of a hospital as specified by the Delaware Department of Health and Social Services:

3.1.4 Copies of management, agency or administrative contracts:

3.1.5 Equifax Reports on Officers/Directors; and/or NAIC biographical or other similar biographical forms, as directed by the Department:

3.1.6 Proof of \$50,000 bond for each officer, director, partner, or other individual who receives, collects or invests money:

3.1.7 "Admittance Questionnaire for Certificate of Authority for Managed Care Organization," Form No. H-2 (Exhibit B to this regulation):

3.1.8 "Designation of official authorized to appoint and remove agents," Form No. H-3 (Exhibit C to this regulation):

3.1.9 "Designation of person to receive bulletins, regulations, etc.," Form No. H-4 (Exhibit D to this regulation):

3.1.10 "Designation of person to receive service of process," Form No. H-5 (Exhibit E to this regulation):

3.1.11 "Biographical Affidavit of Officers and Directors" (Exhibit F to this regulation); and

3.1.12 "Power of Attorney Form" (Exhibit G to this regulation).

3.2 Each application for a Certificate of Authority as a Managed Care Organization shall be accompanied by a \$750 filing fee in accordance with 18 Del. C. §6409.

3.3 Each application for a Certificate of Authority as a Managed Care Organization shall be accompanied by a deposit of \$100,000 in accordance with 18 Del.C. §513(f).

3.4 All of the items and information specified in the foregoing sections 3.1 through 3.3 must be submitted in order for the Department to review an application for a Certificate of Authority.

3.5 Denial of Application for Certificate of Authority

3.5.1 If, within 60 days after a complete application for a Certificate of Authority has been filed, the Department has not issued such certificate, the Department shall immediately notify the applicant, in writing, of the reasons why such certificate has not been issued, and the applicant shall be entitled to request a hearing on the application.

3.5.2 The hearing shall be held within 60 days of the Department's receipt of the applicant's written request therefor. Proceedings in regard to such hearing shall be conducted in accordance with provisions for case decisions as set forth in the Administrative Procedures Act, Chapter 101 of Title 29, and in accordance with applicable rules and regulations of the Department.

4.0 Capital Funds Required

4.1 Each MCO that obtains a Certificate of Authority shall have and maintain unimpaired capital stock or unimpaired basic surplus of at least \$300,000 and free surplus of at least \$150,000 or the minimum capital and free surplus as may be required by legislative changes adopted by the General Assembly from time to time. These capital and surplus requirements are in addition to the deposit requirements of 18 Del.C. §513(f).

4.2 Each MCO that obtains a Certificate of Authority shall demonstrate that it has provider contracts which require that the provider agrees in the event of non-payment by the MCO that the provider will not seek compensation or have any recourse against an enrollee, as described in section 7.0 of this regulation. In the event that the MCO has not entered into such agreements with all providers, the MCO must demonstrate to the Department's satisfaction that it has made a good faith effort to enter into these agreements. In lieu of these executed provider agreements, the Department, at its discretion, may allow the MCO to engage in the business of a managed care organization if the MCO establishes reserves equal to 25% of the total projected annual incurred

claims or benefits payments attributable to the provider which or who has not agreed to enter into a provider agreement.

4.3 Annually, at the time of filing the annual report on June 1, each MCO which has a current Certificate of Authority shall demonstrate that it is in compliance with the requirements of Sections 4.1 and 4.2 of this regulation.

5.0 Reinsurance Requirement

5.1 Each MCO shall secure insurance reinsurance protection to provide to the MCO in the event of catastrophic or unusual losses which would be in excess of the levels of loss which the MCO assumes in the basis of its calculation of premium charges.

6.0 Special Requirement in the Event of Financial Impairment/Insolvency

6.1 In the event of the financial impairment or insolvency of an MCO doing business in this State, each MCO doing business in this State shall permit a 60-day "open enrollment" period for existing enrollees of the impaired/insolvent MCO to enroll in a solvent MCO.

6.2 Each such solvent licensed MCO shall be required to accept within the "open enrollment" period any enrollee who wishes to enroll at the rates or costs and benefits which are then in effect at the chosen MCO for the class or grouping represented by the enrollee.

6.3 Each such solvent licensed MCO shall accept such enrollee without any waiting periods or pre-existing conditions exclusions and such acceptance both as to premium as well as delivery of service shall be retroactive to the date on which a court of competent jurisdiction has declared the predecessor MCO financially impaired.

7.0 Required Contractual Provisions

7.1 Every contract between an MCO and a participating provider shall contain the following language:

7.1.1 "Provider agrees that in no event, including but not limited to nonpayment by the MCO or intermediary, insolvency of the MCO or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or a person (other than the MCO or intermediary) acting on behalf of the enrollee for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to enrollees."

7.1.2 "In the event of an MCO or intermediary insolvency or other cessation of operations, covered services to enrollees will continue through the period for which a premium has been paid to the MCO on behalf of the enrollee or until the enrollee's discharge from an inpatient facility, whichever time is greater. Covered benefits to enrollees confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary."

7.2 The contract provisions that satisfy the requirements of Section 7.1 above shall be construed in favor of the enrollee, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the MCO, and shall supersede any oral or written contrary agreement between a participating provider and an enrollee or the representative of an enrollee if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Section 7.1 above.

7.3 A contract between an MCO and a participating provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in this regulation.

8.0 Enrollee Rights and Responsibilities

8.1 The MCO shall establish and implement written policies and procedures regarding the rights of enrollees and the implementation of these rights.

8.2 The MCO shall disclose to each new enrollee, and any enrollee upon request, in a format and language understandable to a layperson, the following minimum information:

8.2.1 Benefits covered and exclusions or limitations, including restrictions related to preexisting conditions:

8.2.2 Out-of-pocket costs to the enrollee:

8.2.3 Lists of participating providers:

EMERGENCY REGULATIONS

8.2.4 Policies on the use of primary care physicians, referrals, use of out of network providers, and out of area services:

8.2.5 Policies governing the provision of emergency and urgent care:

8.2.6 Written explanation of the internal and external review processes:

8.2.7 For staff model MCOs, the location and hours of its inpatient and outpatient health services:

8.2.8 A statement of enrollee's rights that includes at least the right:

8.2.8.1 To available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions:

8.2.8.2 To be treated with courtesy and consideration, and with respect for the enrollee's dignity and need for privacy:

8.2.8.3 To be provided with information concerning the MCO's policies and procedures regarding products, services, providers, grievance procedures and other information about the organization and the care provided:

8.2.8.4 To choose a primary care provider within the limits of the covered benefits and plan network, including the right to refuse care of specific practitioners:

8.2.8.5 To receive from the enrollee's physician(s) or provider, in terms that the enrollee understands, an explanation of his complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives. If the enrollee is not capable of understanding the information, the explanation shall be provided to his next of kin or guardian and documented in the enrollee's medical record:

8.2.8.6 To formulate advance directives:

8.2.8.7 To all the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the enrollee understands:

8.2.8.8 To prompt notification of termination or changes in benefits, services or provider network:

8.2.8.9 To file a grievance with the MCO and to receive a response to the grievance within a reasonable period of time; and

8.2.8.10 To file a petition for arbitration or appeal for review by an Independent Utilization Review Organization, as appropriate.

8.2.9 A complete statement of responsibilities of enrollees.

8.3 In the case of nonpayment by the MCO to a participating provider for a covered service in accordance with the enrollee's health care contract, the provider may not bill the enrollee. This does not prohibit the provider from collecting coinsurance, deductibles or co-payments as determined by the MCO. This does not prohibit the provider and enrollee from agreeing to continue services solely at the expense of the enrollee, as long as the provider clearly informs the enrollee that the MCO will not cover these services.

9.0 Provider Relations

9.1 An MCO shall establish a mechanism by which participating providers will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.

9.2 An MCO shall establish procedures for resolution of administrative, payment or other disputes between providers and the MCO.

9.3 The MCO shall establish a policy governing termination of providers. The policy shall include at least:

9.3.1 Written notification to each enrollee six weeks prior to the termination or withdrawal from the MCO's provider network of an enrollee's primary care physician except in cases where termination was due to unsafe health care practices; and

9.3.2 Except in cases where termination was due to unsafe health care practices that compromise the health or safety of enrollees, assurance of continued coverage of services at the contract price by a terminated provider for up to 120 calendar days after notification of termination in cases where it is medically necessary for the enrollee to continue treatment with the terminated provider. In cases of the pregnancy of an enrollee, medical necessity shall be deemed to have been demonstrated and coverage shall continue to

completion of postpartum care.

10.0 Prohibited Practices

10.1 An MCO shall not offer incentives to a participating provider to provide less than medically necessary services to an enrollee.

10.2 An MCO shall not penalize a participating provider because the provider, in good faith, reports to State authorities any act or practice by the MCO that jeopardizes patient health or welfare.

10.3 An MCO shall not engage in any other practices prohibited by applicable provisions of Title 18 of the **Delaware Code** and regulations promulgated thereunder.

11.0 Quality Assurance and Operations

11.1 Medical Director's Duties. The medical director shall be responsible for the direction, provision and quality of health care services provided to enrollees, including but not limited to the following:

11.1.1 Establishing policies and procedures covering all health care services provided to enrollees:

11.1.2 Coordinating, supervising and overseeing the functioning of professional services:

11.1.3 Providing clinical direction and leadership to the continuous quality improvement and utilization management programs:

11.1.4 Providing clinical direction to physicians responsible for utilization management determinations:

11.1.5 Establishing a committee responsible for delineating qualifications of participating providers and reviewing and verifying credentials of participating providers:

11.1.6 Evaluating the medical aspects of provider contracts; and

11.1.7 Overseeing the continuing in-service education of professional staff.

11.2 Health Care Professional Credentialing

11.2.1 General Responsibilities. An MCO shall:

11.2.1.1 Establish written policies and procedures for credentialing verification of all health care professionals with whom the MCO contracts and apply these standards consistently;

11.2.1.2 Verify the credentials of a health care professional before entering into a contract with that health care professional;

11.2.1.3 Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures;

11.2.1.4 Retain all records and documents relating to a health care professional's credentialing verification process for not less than four years; and

11.2.1.5 Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

11.2.2 Selection standards for participating providers shall be developed for primary care professionals and each health care professional discipline. The standards shall be used in determining the selection of health care professionals by the MCO, its intermediaries and any provider networks with which it contracts. Selection criteria shall not be established in a manner:

11.2.2.1 That would allow an MCO to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization; or

11.2.2.2 That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization.

11.2.3 Nothing in these regulations shall be construed to require an MCO to select a provider as a participating provider solely because the provider meets the MCO's credentialing verification standards, or to prevent the MCO from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

11.2.4 Verification Responsibilities. An MCO shall:

11.2.4.1 Obtain primary verification of at least the following information about the applicant:

11.2.4.1.1 current license, certification, or registration to render health care in Delaware and history of same;

EMERGENCY REGULATIONS

11.2.4.1.2 current level of professional liability coverage, if applicable;
11.2.4.1.3 status of hospital privileges, if applicable;
11.2.4.1.4 specialty board certification status, if applicable; and
11.2.4.1.5 current Drug Enforcement Agency (DEA) registration certificate, if applicable.

11.2.4.2 Obtain, subject to either primary or secondary verification:
11.2.4.2.1 the health care professional's record from the National Practitioner Data Bank; and

11.2.4.2.2 the health care professional's malpractice history.
11.2.4.3 Not less than every three years obtain primary verification of a participating health care professional's:

11.2.4.3.1 current license or certification to render health care in Delaware;

11.2.4.3.2 current level of professional liability coverage, if applicable;

11.2.4.3.3 status of hospital privileges, if applicable;

11.2.4.3.4 current DEA registration certificate, if applicable; and

11.2.4.3.5 specialty board certification status, if applicable.

11.2.4.4 Require all participating providers to notify the MCO of changes in the status of any of the items listed in this section 11.2.4 at any time and identify for participating providers the individual to whom they should report changes in the status of an item listed in this section 11.2.4.

11.2.5 Health Care Professional's Right to Review Credentialing Verification Information. An MCO shall provide a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification application.

11.3 Provider Network Adequacy

11.3.1 Primary, Specialty and Ancillary Providers

11.3.1.1 The MCO shall maintain an adequate network of primary care providers, specialists, and other ancillary health care resources to serve enrollees at all times.

11.3.1.2 If a plan has an insufficient number of providers that are geographically accessible and available within a reasonable period of time to provide covered health services to enrollees, the MCO shall cover non-network providers, and shall prohibit balance billing.

11.3.1.3 The MCO shall allow referral to a non-network provider, upon the request of a network provider, when medically necessary covered health services are not available through network providers, or the network providers are not available within a reasonable period of time. The MCO shall make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing.

11.3.2 Facility and Ancillary Health Care Services

11.3.2.1 The MCO shall maintain contracts or other arrangements acceptable to the Department with institutional providers which have the capability to provide covered health services to enrollees and are geographically accessible.

11.3.2.2 The MCO shall make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing, if the appropriate level of service is not geographically accessible. These services will not be limited to the State of Delaware. These services could include but are not limited to tertiary services, burn units and transplant services.

11.3.3 Emergency and Urgent Care Services

11.3.3.1 The MCO shall establish written policies and procedures governing the provision of emergency and urgent care which shall be distributed to each enrollee at the time of initial enrollment and after any revisions are made. These policies shall be easily understood by a layperson.

11.3.3.2 When emergency care services are performed by non-network providers, the MCO shall make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing. In those cases where the MCO and the provider cannot agree upon the appropriate charge, the provider may petition the Department for arbitration.

11.3.3.3 Enrollees shall have access to emergency care 24 hours per day, seven days per week. The MCO shall cover emergency care necessary to screen and stabilize an enrollee and shall not require prior authorization of such services if a prudent lay person acting reasonably would have believed that an emergency medical condition existed.

11.3.3.4 Emergency and urgent care services shall include but are not limited to:

11.3.3.4.1 medical and psychiatric care, which shall be available 24 hours a day, seven days a week;

11.3.3.4.2 trauma services at any designated Level I or II trauma center as medically necessary. Such coverage shall continue at least until the enrollee is medically stable, no longer requires critical care, and can be safely transferred to another facility, in the judgment of the treating physician. If the MCO requests transfer to a hospital participating in the MCO network, the patient must be stabilized and the transfer effected in accordance with federal regulations at 42 CFR 489.20 and 42 CFR 489.24;

11.3.3.4.3 out of area health care for urgent or emergency conditions where the enrollee cannot reasonably access in-network services;

11.3.3.4.4 hospital services for emergency care; and

11.3.3.4.5 upon arrival in a hospital, a medical screening examination, as required under federal law, as necessary to determine whether an emergency medical condition exists.

11.3.3.5 When an enrollee has received emergency care from a non-network provider and is stabilized, the enrollee or the provider must request approval from the MCO for continued post-stabilization care by a non-network provider. The MCO is required to approve or disapprove coverage of post-stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of services and the condition of the enrollee, but in no case to exceed one hour from the time of the request.

11.3.4 The MCO shall submit evidence of network adequacy to the Department upon request. If the Department receives a complaint regarding an MCO's network adequacy, the burden shall be on the MCO to prove network adequacy to the satisfaction of the Department.

11.4 Utilization Management

11.4.1 The MCO shall establish and implement a comprehensive utilization management program to monitor access to and appropriate utilization of health care and services. The program shall be under the direction of a designated physician and shall be based on a written plan that is reviewed at least annually.

11.4.2 Utilization management determinations shall be based on written clinical criteria and protocols reviewed and approved by practicing physicians and other licensed health care providers within the network. These criteria and protocols shall be periodically reviewed and updated, and shall, with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to affected providers and enrollees.

11.4.3 All materials including internal or proprietary materials for utilization management shall be available to the Department upon request.

11.4.4 Compensation to persons providing utilization review services for an MCO shall not contain incentives, direct or indirect, for these persons to make inappropriate review decisions. Compensation to any such persons may not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

11.4.5 Utilization Management Staff Availability

11.4.5.1 At a minimum, appropriately qualified staff shall be immediately available by telephone, during routine provider work hours, to render utilization management determinations for providers.

11.4.5.2 The MCO shall provide enrollees with a toll free telephone number by which to contact customer service staff on at least a five day, 40 hours a week basis.

11.4.5.3 The MCO shall supply providers with a toll free telephone number by which to contact utilization management staff on at least a five day, 40 hours a week basis.

11.4.5.4 The MCO must have policies and procedures addressing response to inquiries concerning emergency or urgent care when a PCP or his authorized on call back up provider is unavailable.

11.4.6 Utilization Management Determinations

11.4.6.1 All determinations to authorize services shall be rendered by appropriately qualified staff.

11.4.6.2 All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the MCO's Delaware enrollees. Such determinations shall be made in accordance with clinical and medical criteria and standards and shall take into account the individualized needs of the enrollee for whom the service, admission, procedure or extension is requested.

EMERGENCY REGULATIONS

11.4.6.3 All determinations shall be made on a timely basis as required by the exigencies of the situation.

11.4.6.4 An MCO may not retroactively deny reimbursement for a covered health service provided to an enrollee by a provider who relied upon the written or verbal authorization of the MCO or its agents prior to providing the service to the enrollee, except in cases where the MCO can show that there was material misrepresentation, fraud or the patient was found not to have coverage.

11.4.6.5 An enrollee must receive written notice of all determinations to deny coverage or authorization for services required and the basis for the denial.

11.5 Quality Assessment and Improvement

11.5.1 Continuous Quality Improvement

11.5.1.1 Under the direction of the Medical Director or his designated physician, the MCO shall have a system-wide continuous quality improvement program to monitor the quality and appropriateness of care and services provided to enrollees. This program shall be based on a written plan which is reviewed at least semi-annually and revised as necessary.

11.5.1.2 The MCO shall assure that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system.

11.5.1.3 The MCO shall provide enrollees the opportunity to comment on the quality improvement process.

11.5.1.4 The MCO shall follow up on findings from the program to assure that effective corrective actions have been taken, including at least policy revisions, procedural changes and implementation of educational activities for enrollees and providers.

11.5.1.5 The MCO shall make documentation regarding the quality improvement program available to the Department upon request.

11.5.2 External Quality Audit

11.5.2.1 Each MCO shall submit, as a part of its annual report due June 1, evidence of its most recent external quality audit that has been conducted or of acceptable accreditation status.

11.5.2.2 The report of the external quality audit must describe in detail the MCO's conformance to performance standards and the rules within this regulation. The report shall also describe in detail any corrective actions proposed and/or undertaken by the MCO.

11.5.2.3 External quality audits must be completed no less frequently than once every three years. Such audit shall be performed by a nationally known accreditation organization or an independent quality review organization acceptable to the Department.

11.5.2.4 In lieu of the external quality audit, the Department may accept evidence that an MCO has received and has maintained the appropriate accreditation from a nationally known accreditation organization or independent quality review organization.

11.5.3 Reporting and Disclosure Requirements

11.5.3.1 An MCO shall document and communicate information about its quality assessment program and its quality improvement program, and shall:

11.5.3.1.1 include a summary of its quality assessment and quality improvement programs in marketing materials;

11.5.3.1.2 include a description of its quality assessment and quality improvement programs and a statement of enrollee rights and responsibilities with respect to those programs in the materials or handbook provided to enrollees; and

11.5.3.1.3 make available annually to participating providers and enrollees findings from its quality assessment and quality improvement programs and information about its progress in meeting internal goals and external standards, where available. The reports shall include a description of the methods used to assess each specific area and an explanation of how any assumptions affect the findings.

11.5.3.2 An MCO shall submit to the Department such performance and outcome data as the Department may request.

12.0 Recordkeeping and Reporting Requirements

12.1 Medical Records Retention

12.1.1 The MCO must maintain or provide for the maintenance of a medical records system which meets the accepted standards of the health care industry and State and federal regulations.

12.1.1.1 The MCO shall provide sufficient space and equipment for the processing and the safe storage of records.

12.1.1.2 Medical records shall be protected from loss, damage and unauthorized use.

12.1.2 Retention and Destruction

12.1.2.1 With the exception of medical records of minors (individuals under the age of 18 years), medical records shall be preserved as original records, on microfilm or electronically stored for no less than five years after the most recent patient care usage, after which time records may be destroyed at the discretion of the MCO.

12.1.2.2 Medical records of minors shall be preserved for the period of minority plus five years (i.e., 23 years) or as otherwise required by State law.

12.1.2.3 An MCO shall establish procedures for notification to patients whose records are to be destroyed prior to the destruction of such records.

12.1.3 The Department shall have access to medical records for purposes of monitoring and review of MCO practices.

12.2 Reporting Requirements and Statistics

12.2.1 Annual reports. In addition to the information required to be included in an MCO's annual report as specified in 18 Del.C. §6406 or elsewhere in this regulation, an MCO shall submit the following information to the Department on an annual basis:

12.2.1.1 A statistical summary evaluating the network adequacy and accessibility to the enrolled population;

12.2.1.2 Annual appeal report of all grievances, petitions for arbitration and appeals under the Independent Health Care Appeals Program as required under Department Regulation 1301.

12.2.1.3 Evidence of compliance with the capital funds requirements of section 4.0 of this regulation.

12.2.2 An MCO shall submit the following information to the Department whenever there is a change:

12.2.2.1 Substantial changes in organization, bylaws, or governing board

12.2.2.2 Full name of the Chief Executive Officer

12.2.2.3 Full name of the Medical Director

12.2.2.4 Substantial changes in marketing materials, grievance procedures or the utilization management program

12.2.2.5 Any significant amendment to or revision relating to the text or subtext of an approved provider contract shall be submitted to and approved by the Department prior to the execution of an amended or revised contract with the providers of an MCO.

13.0 Compliance with Regulation

13.1 The MCO is responsible for meeting each requirement of this regulation. If the MCO chooses to utilize contract support or to contract functions under this regulation, the MCO retains responsibility for ensuring that the requirements of this regulation are met.

13.2 The Department may require a corrective action plan from an MCO when the Department determines that the MCO is not in compliance with applicable provisions of Title 18 of the Delaware Code or regulations promulgated thereunder.

14.0 Separability Provisions

14.1 If any provision of this regulation shall be held invalid, the remainder of the regulation shall not be affected thereby.

Symbol Key

Arial type indicates the text existing prior to the regulation being promulgated. Underlined text indicates new text. Language which is ~~stricken~~ through indicates text being deleted.

Proposed Regulations

Under 29 **Del.C.** §10115 whenever an agency proposes to formulate, adopt, amend or repeal a regulation, it shall file notice and full text of such proposals, together with copies of the existing regulation being adopted, amended or repealed, with the Registrar for publication in the *Register of Regulations* pursuant to §1134 of this title. The notice shall describe the nature of the proceedings including a brief synopsis of the subject, substance, issues, possible terms of the agency action, a reference to the legal authority of the agency to act, and reference to any other regulations that may be impacted or affected by the proposal, and shall state the manner in which persons may present their views; if in writing, of the place to which and the final date by which such views may be submitted; or if at a public hearing, the date, time and place of the hearing. If a public hearing is to be held, such public hearing shall not be scheduled less than 20 days following publication of notice of the proposal in the *Register of Regulations*. If a public hearing will be held on the proposal, notice of the time, date, place and a summary of the nature of the proposal shall also be published in at least 2 Delaware newspapers of general circulation. The notice shall also be mailed to all persons who have made timely written requests of the agency for advance notice of its regulation-making proceedings.

DEPARTMENT OF EDUCATION**OFFICE OF THE SECRETARY**

Statutory Authority: 14 Delaware Code, Section 122(d) (14 **Del.C.** §122(d))
14 **DE Admin. Code** 502

Education Impact Analysis Pursuant To 14 Del.C. Section 122(d)**502 Alignment of Local School District Curricula to the State Content Standards****A. Type of Regulatory Action Required**

Amendment to Existing Regulation

B. Synopsis of Subject Matter of the Regulation

The Secretary of Education intends to amend 14 **DE Admin. Code** 502 Section 6.0 in order to clarify the descriptions of the categories of evidence of alignment to the state content standards that are required for submission to the Department of Education and to change the grade cluster configuration. The changes have been made as a result of a pilot study involving unofficial review of curriculum evidence from a small number of districts.

Persons wishing to present their views regarding this matter may do so in writing by the close of business on Monday March 5, 2007 to Carol O'Neill Mayhew, Education Associate, Regulation Review, Department of Education, at 401 Federal Street, Suite 2, Dover, DE 19901. A copy of this regulation is available from the above address or may be viewed at the Department of Education business office.

C. Impact Criteria

1. Will the amended regulation help improve student achievement as measured against state achievement standards? The purpose of the alignment project is to insure that the curriculum in all of the school districts is aligned with the state content standards which should assist in improving student achievement.

2. Will the amended regulation help ensure that all students receive an equitable education? The alignment project should help to ensure that all students receive an equitable education.

3. Will the amended regulation help to ensure that all students' health and safety are adequately protected? The amended regulation addresses alignment of curriculum with the state content standards not health and safety issues.

4. Will the amended regulation help to ensure that all students' legal rights are respected? The amended regulation addresses alignment of curriculum with the state content standards not students legal rights.
5. Will the amended regulation preserve the necessary authority and flexibility of decision making at the local board and school level? The amended regulation will preserve the necessary authority and flexibility of decision making at the local board and school level.
6. Will the amended regulation place unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels? The amended regulation does include reporting requirements concerning curriculum alignment to the state content standards.
7. Will the decision making authority and accountability for addressing the subject to be regulated be placed in the same entity? The decision making authority and accountability for addressing the subject to be regulated will remain in the same entity.
8. Will the amended regulation be consistent with and not an impediment to the implementation of other state educational policies, in particular to state educational policies addressing achievement in the core academic subjects of mathematics, science, language arts and social studies? The amended regulation will be consistent with and not an impediment to the implementation of other state educational policies, in particular to state educational policies addressing achievement in the core academic subjects of mathematics, science, language arts and social studies.
9. Is there a less burdensome method for addressing the purpose of the regulation? There is no less burdensome method for addressing the purpose of the regulation.
10. What is the cost to the State and to the local school boards of compliance with the regulation? There may be some cost to the local school districts in staff time and or consultants as they align their curriculum with the state content standards.

502 Alignment of Local School District Curricula to the State Content Standards

1.0 Purpose

The purpose of this regulation is to provide a process through which all Delaware school districts demonstrate the alignment of their local curricula with the State Content Standards in the content areas specified in the 14 **DE Admin. Code 501**.

2.0 Definitions

“Alignment Index” means a correlational measure of alignment between the Survey of Enacted Curriculum in a specific content area and the state standards used for comparison. The Wisconsin Center for Educational Research automatically calculates and reports the alignment index to schools and districts that use the surveys.

“Content Map” means a graphic depiction of local curriculum alignment automatically reported to schools and districts as part of the analysis of teacher survey data by the Wisconsin Center for Educational Research.

“Department” means the Delaware Department of Education.

“Grade Level Expectations” means the documents created and officially released by the Delaware Department of Education for English language arts, mathematics, science, and social studies which detail student learning objectives in each content area for kindergarten through grade twelve.

“Scope and Sequence” means a curriculum plan, usually in chart form, with a range of instructional objectives and skills organized according to the successive levels at which they are taught.

“Statewide Recommended Curriculum Frameworks” means the Delaware Recommended Curriculum documents comprised of Academic Content Standards, Clarifications and Grade Level Expectations posted to the Delaware Department of Education website.

“Survey of Enacted Curriculum (SEC)” means the alignment survey sponsored by the Council of Chief State School Officers and the Wisconsin Center for Education Research. The SEC is a teacher survey tool based on scientifically based research which yields detailed information about the alignment of classroom instruction to state academic standards and state assessments. The survey is available for English language arts, mathematics, and science at the present time. A survey for social studies is in development. An analysis of results by grade level, school and district is completed by the Wisconsin Center for Educational Research with formal reports provided to the participating schools and districts.

“**Tile Chart**” means a graphic depiction of local curriculum alignment automatically reported to schools and districts as part of the analysis of teacher survey data by the Wisconsin Center for Educational Research.

“**Unit Summative Assessment**” means a performance measure of skills and knowledge mastered by students at the end of a unit as a result of classroom instruction. Examples of unit assessment measures include but are not limited to teacher constructed unit tests and commercially published measures such as those provided by curriculum publishers.

3.0 Alignment Requirement

All school districts shall provide evidence to the Department that their school district curricula are aligned with the State Content Standards. As of 2006 State Content Standards exist in English Language Arts, Mathematics, Social Studies, Science, World Languages, Visual and Performing Arts, Health, Physical Education, Agriscience, Business Finance and Marketing Education, Technology Education, and the Family and Consumer Sciences. Content standards as developed by the Department in the future shall also be included under this section.

4.0 Use of the Statewide Recommended Curricula Frameworks

School districts shall utilize the Statewide Recommended Curricula Frameworks including the State Content Standards, Content Area Clarifications and Grade Level Expectations as guides to the development or revision of their local curricula, syllabi, and Scope and Sequence in the content areas listed in 3.0.

5.0 Documentation of Curriculum Alignment

5.1 Evidence of curriculum alignment to the State Content Standards shall be submitted to the Department no later than twelve (12) months following the official release by the Department of the Statewide Recommended Curriculum Frameworks in each content area.

5.2 Documentation of alignment of school district curriculum to the State Content Standards shall be submitted through evidence provided by the school districts on forms as developed and required by the Department .

5.3 Evidence of curriculum alignment submitted by school districts shall be subject to Department review during on site monitoring visits.

6.0 Criteria for the Evaluation of the Alignment

6.1 School districts shall be required to submit evidence of local curriculum alignment for each grade cluster ~~(K-5, 6-8 and 9-12)~~ K to 2, 3 to 5, 6 to 8 and 9 to 12 from at least two of the permissible categories of evidence in 6.1.1 through 6.1.6. One of the two categories shall be the evidence described in 6.1.1. The second required category and any additional submitted evidence shall be selected by the district from categories 6.1.2 through 6.1.6. The school district may choose to vary the choice of the second category of evidence by grade cluster level. Evidence of alignment to each standard in a given content area shall be submitted.

6.1.1 Category 1 is a narrative describing the local curriculum alignment evidence and the extent to which it addresses all student subgroups. For English language arts, mathematics, science and social studies, a required element of this narrative shall be an analysis of school district disaggregated student performance data on state assessments over the most recent three year period of available state assessment data.

6.1.2 Category 2 is the Grade level result (all teachers in at least one grade per grade cluster ~~K-5, 6-8 and 9-12~~) K to 2, 3 to 5, 6 to 8 and 9 to 12 of the Survey of Enacted Curriculum for the content area under consideration. The SEC results shall demonstrate an Alignment Index of .50 or higher, and include a graphic summary including either a Tile Chart or Content Maps.

~~6.1.3 Category 3 is one unit of study from each marking period with a corresponding Unit Summative Assessment, showing the academic standards addressed. Evidence shall be from grades 3, 5, 8 and 10.~~

~~6.1.4 Category 4 is a description of the Scope and Sequence with a matrix of the primary academic standards addressed for each grade cluster.~~

~~6.1.5 Category 5 is an external formal curriculum alignment report detailing a review of local instruction and documentation of standards alignment. The contractor's credentials shall be submitted.~~

~~6.1.6 Category 6 is a grade cluster Scope and Sequence with a sample unit from each grade cluster, combined with student assessment results. Evidence of alignment of formative student progress to the~~

~~State Content Standards shall be required. For districts using commercial student progress assessments, evidence shall include evidence of alignment of student progress assessments to the Delaware content standards.~~

6.1.3 Category 3 is three (3) units of study from a specific grade cluster, accompanied by the corresponding summative unit assessment and scoring rubric, and matrix table detailing applicable content standards, grade level expectations and course expectations for all students served in the grade cluster.

6.1.4 Category 4 is an external formal curriculum alignment report detailing a review of local instruction and documentation of standards alignment. The district is required to submit three (3) sample units and three (3) corresponding unit summative assessments, and a narrative detailing how all students served in the grade cluster receive standards aligned instruction. The district is required to submit the curriculum audit contractor's credentials.

6.1.5 Category 5 is a formative assessment benchmarking system with grade cluster Scope and Sequence, including three sample units from the grade cluster. The district is required to submit (1) a narrative detailing evidence of alignment of formative student assessment or assessments to the State Content Standards and (2) sample assessment items in the content area.

6.2 Required documentation for specific student subpopulations

6.2.1 As part of its submitted evidence, the district shall make detailed comments on the extent to which any modification or enhancement of the instructional program for specific subgroups such as students with disabilities, gifted students, English language learners or any other special population of students is aligned to the State Content Standards in the content area where there have been modifications or enhancements.

7.0 Participation of Building Level Staff

All school districts shall describe and document to the Department the method and the level of involvement in the alignment process by their building administrators, teachers and specialists.

8.0 Subsequent Review of Alignment

Each district shall resubmit evidence of alignment with the State Content Standards on forms developed and required by the Department between three and five years from the initial approval and on a recurring cycle of three to five years as determined by the Department. Further provided, the district shall be required to present evidence of curriculum alignment if there are major changes to a content area in the approved curricula. The district shall only be required to submit evidence of curriculum alignment in the affected content area.

10 DE Reg. 344 (8/1/06)

OFFICE OF THE SECRETARY

Statutory Authority: 14 Delaware Code, Section 122(d) (14 Del.C. §122(d))
14 DE Admin. Code 540

Education Impact Analysis Pursuant To 14 Del.C. Section 122(d)

540 Driver Education

A. Type of Regulatory Action Required

Amendment to Existing Regulation

B. Synopsis Of Subject Matter Of The Regulation

The Secretary of Education seeks the consent of the State Board of Education to amend 14 DE Admin. Code 540 Driver Education in order to correct the title of the Educate Associate, change the reference from sophomore(s) to 10th grade(rs), change the reference to the curriculum requirement and change the format of 6.0. The recent changes in the **Delaware Code** concerning driver's licenses do not require changes to the regulation.

Persons wishing to present their views regarding this matter may do so in writing by the close of business on Monday March 5, 2007 to Carol O'Neill Mayhew, Education Associate, Regulation Review, Department of

Education, at 401 Federal Street, Suite 2, Dover, DE 19901. A copy of this regulation is available from the above address or may be viewed at the Department of Education business office.

C. Impact Criteria

1. Will the amended regulation help improve student achievement as measured against state achievement standards? The amendments did not change the content of the regulation.
2. Will the amended regulation help ensure that all students receive an equitable education? The amendments did not change the content of the regulation.
3. Will the amended regulation help to ensure that all students' health and safety are adequately protected? The amendments did not change the content of the regulation.
4. Will the amended regulation help to ensure that all students' legal rights are respected? The amendments did not change the content of the regulation.
5. Will the amended regulation preserve the necessary authority and flexibility of decision making at the local board and school level? The amendments did not change the content of the regulation.
6. Will the amended regulation place unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels? The amendments did not change the content of the regulation.
7. Will the decision making authority and accountability for addressing the subject to be regulated be placed in the same entity? The amendments did not change the content of the regulation.
8. Will the amended regulation be consistent with and not an impediment to the implementation of other state educational policies, in particular to state educational policies addressing achievement in the core academic subjects of mathematics, science, language arts and social studies? The amendments did not change the content of the regulation.
9. Is there a less burdensome method for addressing the purpose of the regulation? There is no less burdensome method for addressing the purpose of the regulation.
10. What is the cost to the State and to the local school boards of compliance with the amended regulation? There is no cost to the State and to the local school boards of compliance with the amended regulation.

540 Driver Education

1.0 Eligibility for Driver Education

Delaware residents are entitled to free driver education one time only. Students who are not successful in their initial driver education course may register in any of the adult driver education programs for a fee.

1.1 The Individualized Education Program Team, in consultation with the Driver Education teacher, may make accommodations to the Driver Education program and offer specialized instruction for special education students through the student's Individual Education Program (I.E.P.).

1.2 Nothing in this regulation shall alter a school's duties under Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act to students who are qualified individuals with disabilities. Nothing in this regulation shall prevent a school from providing driver education to such students.

1.3 Delaware residents attending school out of state as ~~sophomores~~ 10th graders, students in excess of the September 30th unit allotment, students attending private and parochial academies in state with ~~sophomore~~ 10th grade enrollments of less than twenty five, home schooled students and any student approved by the Secretary as an exceptional case are entitled to attend summer driver education without charge. Districts shall notify all nonpublic and public high schools in their district by May 1st annually as to the location of the nearest summer driver education program. Summer Driver Education shall be offered between June 10 and August 31 and each request for free tuition must be approved by the Secretary of Education through the Office of the Education Associate for ~~Driver Education, Safety and Physical Education, Safety and Driver Education.~~

1.4 Adult Driver Education programs, when offered, shall follow the same regulations established for the high school and the summer programs. The adult programs are available to any individual for a fee through a local school district in each county. The cost per student for adult driver education will be determined by the Department of Education.

2.0 Requirements for Class Time

The driver education course shall include a minimum of forty four (44) class hours of instruction consisting of thirty (30) class hours of classroom instruction, seven (7) class hours of in the car behind the wheel laboratory instruction and seven (7) hours of actual observation in the car. The class hours must not be less than forty five (45) minutes each. For those schools with varying class schedules the minimum classroom instruction must be no less than one thousand three hundred fifty (1350) minutes and behind the wheel laboratory instruction no less than three hundred fifteen (315) minutes.

2.1 Driving simulators may be substituted for the required hours of behind the wheel laboratory instruction but only up to three (3) hours of time at the ratio of four (4) hours of driving simulation to one (1) hour of actual behind the wheel laboratory instruction.

2.2 Off the street driving ranges or multiple driving ranges that are off the street may be substituted for actual behind the wheel laboratory instruction up to three (3) hours time at the ratio of two (2) hours of range instruction time to one (1) hour of actual behind the wheel laboratory instruction time.

2.3 Driving simulation and off the street driving range time shall not be taken from or cause a reduction of classroom instruction time.

2.4 Driving simulation and off the street driving range time shall not be substituted for more than one half (1/2) of the total required seven (7) hours of actual behind the wheel laboratory instruction and only at the ratios defined in the above items. This includes individually or in any combination.

3.0 Curriculum

The Driver Education teachers shall use the ~~"Teachers' Guide for Driver Education"~~ statewide curriculum for driver education developed by the Department of Education for classroom instruction and behind the wheel laboratory instruction time. Teachers should include student activities requiring reading, writing and research as part of the Driver Education curriculum.

4.0 Final Grades

Final grades for the forty four hour driver education course shall be either pass or fail. Schools may grant one fourth (1/4) credit for successful completion of the minimum hours in both the classroom and the behind the wheel laboratory experience. The one fourth credit for driver education may be included as part of the elective credits counted toward graduation.

4.1 Pass or Fail grades must be received by the Department of Education no later than June 30th for Regular Driver Education Programs and August 31st for Summer Driver Education Programs. Final grades will be maintained by the Department for a seven year period.

5.0 Use of Driver Education Cars

Automobiles purchased, leased from Fleet Services or leased directly from a dealership using state funds allocated for driver education shall be used solely for the instruction of students enrolled in Driver Education; except that a school district or charter school may permit a driver education teacher to drive such automobile to and from the teacher's place of residence when the school district or charter school determines that it would be unsafe to store the automobile overnight at the school; and further provided that in the case of a private school driver education teacher, the Education Associate ~~for Driver Education and Physical Education, Safety and Driver Education~~ at the Department of Education may permit that teacher to drive the automobile to and from school from the teacher's place of residence when it appears that it would be unsafe to store the automobile overnight at the school.

6.0 ~~All Public and Nonpublic High Schools with Enrollments of Twenty Five or More Sophomore Students Shall Offer Driver Education as an Integral Part of the Curriculum.~~ Scheduling of Driver Education

6.1 All public and nonpublic high schools with twenty five or more enrolled 10th grade students shall offer Driver Education as part of the curriculum.

1 DE Reg. 964 (1/1/98)

6 DE Reg. 773 (12/1/02)

PROPOSED REGULATIONS

PROFESSIONAL STANDARDS BOARD

Statutory Authority: 14 Delaware Code, Section 122(d) (14 Del.C. §122(d))
14 DE Admin. Code 1501

Education Impact Analysis Pursuant To 14 Del.C. Section 122(d)

1501 Knowledge, Skills and Responsibility Based Salary Supplements for Educators

A. Type of Regulatory Action Requested

Amendment to Existing Regulation

B. Synopsis of Subject Matter of Regulation

The Professional Standards Board, acting in cooperation and collaboration with the Department of Education, seeks the consent of the State Board of Education to amend regulation **DE Admin. Code 1501 Knowledge, Skills and Responsibility Based Salary Supplements for Educators**. It is necessary to amend this regulation in order to clarify criteria surrounding cluster expiration dates, replication, reauthorization and payment of salary supplements.

Persons wishing to present their views regarding this matter may do so in writing by the close of business on March 3, 2007 to Mr. Charlie Michels, Executive Director, Delaware Professional Standards Board, The Townsend Building, 401 Federal Street, Dover, Delaware 19901. Copies of this regulation are available from the above address or may be viewed at the Professional Standards Board Business Office.

C. Impact Criteria

1. Will the amended regulation help improve student achievement as measured against state achievement standards? The amended regulation addresses student achievement through enhanced educator knowledge and skills. The regulation requires that knowledge and skills lead to more effective instruction and that responsibility supplements impact student achievement.

2. Will the amended regulation help ensure that all students receive an equitable education? The amended regulation helps ensure that all educators have access to high quality opportunities to acquire knowledge and skills that lead to more effective instruction. It does not address student equity.

3. Will the amended regulation help to ensure that all students' health and safety are adequately protected? The amended regulation addresses educator knowledge, skills, and responsibility based salary supplements, not students' health and safety issues.

4. Will the amended regulation help to ensure that all students' legal rights are respected? The amended regulation addresses educator knowledge, skills, and responsibility based salary supplements, not students' legal rights.

5. Will the amended regulation preserve the necessary authority and flexibility of decision-makers at the local board and school level? The amended regulation will preserve the necessary authority and flexibility of decision makers at the local board and school level.

6. Will the amended regulation place unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels? The amended regulation will not place unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels.

7. Will decision making authority and accountability for addressing the subject to be regulated be placed in the same entity? The decision-making authority and accountability for addressing the subject to be regulated rests with the Professional Standards Board, in collaboration with the Department of Education, and with the consent of the State Board of Education.

8. Will the amended regulation be consistent with and not an impediment to the implementation of other state educational policies, in particular to state educational policies addressing achievement in the core academic subjects of mathematics, science, language arts and social studies? The amended regulation will be consistent with, and not an impediment to, the implementation of other state educational policies, in particular to state educational policies addressing achievement in the core academic subjects of mathematics, science, language arts and social studies.

9. Is there a less burdensome method for addressing the purpose of the amended regulation? 14 **Del.C.** requires that we promulgate this regulation.

10. What is the cost to the state and to the local school boards of compliance with the adopted regulation? There is no additional cost to local school boards for compliance with the regulation.

1501 Knowledge, Skills, and Responsibility Based Salary Supplements for Educators

1.0 Content

1.1 The following requirements shall be met in order to receive the salary supplements established by 14 **Del.C.** §1305. This regulation shall apply to the awarding of salary supplements as a percentage of the state portion of an educator's annual salary paid in accordance with the provisions of 14 **Del.C.** §1305 for gaining knowledge and skills that lead to more effective instruction, for achieving certification from the National Board for Professional Teaching Standards, or from an equivalent program, and for accepting additional responsibility assignments that impact student achievement. Supplements are available subject to an annual appropriation from the Legislature.

5 DE Reg. 2297 (06/01/02)

8 DE Reg. 73 (07/01/04)

2.0 Definitions

The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise:

"Approved Cluster" means a professional development cluster that meets the criteria specified in 3.1 of this Regulation and that has been approved by the Standards Board and the State Board as the basis for awarding a specific salary supplement.

"Base Salary" means the salary earned by the educator as determined by their level of education and years of service on the Delaware educators' salary schedule pursuant to 14 **Del.C.** §1305(a) and (b).

"Delaware Administrator Standards" means standards for education administrators approved by the Standards Board and the State Board of Education, as per 14 **DE Admin. Code** 1594, Delaware Administrator Standards.

"Delaware Content Standards" means K to 12 curriculum content standards approved by the Secretary of Education and the State Board of Education, as per 14 **DE Admin. Code** 501, State Content Standards.

"Delaware Professional Teaching Standards" means standards for teachers approved by the Standards Board and the State Board of Education, as per 14 **DE Admin. Code** 1593, Delaware Professional Teaching Standards.

"Department" means the Delaware Department of Education.

"Educator" means a public school employee who holds a license issued under the provisions of 14 **Del.C.** Ch. 12, and includes teachers, specialists, and administrators, and as otherwise defined by the Standards Board and the State Board pursuant to 14 **Del.C.** §1203, but does not include substitute teachers.

"Hours of Engagement" means time spent in classes, seminars, workshops, collaborative work groups, learning communities, cohort, school, or district teams, and time engaged in research based activities which result in the acquisition of knowledge and skills which lead to more effective instruction.

"Knowledge and Skills" means understandings and abilities that, when acquired by educators, lead to more effective instruction.

"NSDC Standards for Staff Development" means standards adopted by the National Staff Development Council for high quality staff and professional development.

"Professional Development Cluster" or **"Cluster"** means a focused group of professional development activities that leads to measurable and observable knowledge and skills.

"Provider" means a local school district, charter school, college, educationally related organization, or professional organization that delivers professional development clusters approved by the Standards Board and the State Board to educators.

"Reauthorization of an Approved Cluster" means the process a provider uses to seek continued approval, after the initial five year approval period, of an previously approved cluster.

"Replication of Approved Clusters" means an approved cluster being delivered by a provider other than the developer of the original approved cluster provider.

~~**"Requalification of an Approved Cluster"** means the process a provider uses to set forth the activities that an educator would engage in to qualify for an extension of five (5) additional years of a salary supplement.~~

"Responsibility Assignments" means additional assignments for educators that are academic in nature and that impact student achievement. For purposes of this regulation and pursuant to 14 **Del.C.** §1305(o) extra curricular or noninstructional supervisory activities are specifically excluded from responsibility assignments.

"Salary Supplement", when referring to knowledge, skills, and responsibility based supplements, means additional state salary, as described in 14 **Del.C.** §1305.

"Standards Board" means the Professional Standards Board of the State of Delaware established in response to 14 **Del.C.** §1205.

"State Board" means the State Board of Education of the State of Delaware established in response to 14 **Del.C.** §104.

8 DE Reg. 73 (07/01/04)

3.0 Knowledge and Skills

3.1 The Standards Board shall, on no less than an annual basis, submit to the State Board for approval, lists of proposed new professional development clusters in specific areas of knowledge and skills which shall serve as the basis for awarding salary supplements.

3.2 The criteria for evaluating professional development clusters designed to promote acquisition of knowledge and skills are based upon:

3.2.1 Delaware Professional Teaching Standards or Delaware Administrator Standards or their equivalent (i.e., national standards from educators' specialty area organizations that complement the Delaware standards).

3.2.2 Delaware content standards or their equivalent (i.e., national standards from content specialty groups, if there are no Delaware standards for the content area).

3.2.3 National Staff Development Council Standards for Staff Development (NSDC, 2001).

3.3 Clusters may include a combination of formal courses at graduate or undergraduate levels, and other research based activities which conform to the NSDC Standards for Staff Development.

3.4 Clusters may be comprised of related segments which may be completed separately over a specified period of time, not to exceed 5 years, as included in the cluster design and approved by the Standards Board and the State Board.

3.5 Voluntary performance or assessment based specialty certifications awarded for meeting standards established by national professional organizations shall be evaluated as proposed clusters in accordance with this regulation.

3.6 The specific percentage of salary assigned to each knowledge and skills supplement, provided that no supplement may be less than 2% nor more than 6% of an educator's base state salary, shall be submitted with the list of professional development clusters and specific areas of knowledge and skills.

3.6.1 A cluster qualifying an educator for a supplement of 2% shall consist of no less than 90 hours of engagement by the educator.

3.6.2 A cluster qualifying an educator for a supplement of 4% shall consist of no less than 180 hours of engagement by the educator.

3.6.3 A cluster qualifying an educator for a supplement of 6% shall consist of no less than 270 hours of engagement by the educator.

3.7 Knowledge and skills which, once acquired, are expected to lead to more effective instruction for the duration of an educator's career are designated as permanent supplements.

3.8 Knowledge and skills clusters related to new technologies, curriculum adoptions, and short term strategies shall have a an initial approval duration of five (5) years. ~~Educators may requalify for a cluster for an additional five (5) years by completing the activities set forth in accordance with cluster requalification procedures established by the Standards Board.~~

3.8.1 The initial five (5) year duration will begin on the date the State Board approves the cluster and will terminate five (5) years from that date.

3.8.2 A cluster cohort must be assembled and the provider must enter the cohort onto the DEEDS site prior to the cluster termination date. The provider will then make all efforts to complete the cluster in a

timely fashion and to complete the online requirements to complete the process.

3.9 The provider shall present an educator who satisfactorily completes an approved cluster with a certificate of completion to verify eligibility for a salary supplement. The certificate shall certify the knowledge and skills acquired and demonstrated by the educator. The provider shall provide the Department with a list of educators who have satisfactorily completed an approved cluster.

8 DE Reg. 73 (07/01/04)

4.0 Replication of Approved Clusters

4.1 The developer of an approved cluster shall decide if a cluster can be replicated, and shall set forth the conditions, if any, under which the approved cluster may be offered by a provider other than the developer of the approved cluster. The Professional Development and Associated Compensation Committee shall review and approve applications for replication of a cluster, and shall forward approved applications for replication to the Standards Board for action. The Standards Board shall forward approved applications for replication to the State Board for concurrence.

4.1.1 The cluster replication may be offered to participants only within the time period for which the original cluster was approved

4.1.2 A replication cohort must be assembled and the provider must enter the cohort onto the DEEDS site prior to the original cluster termination date. The provider will then make all efforts to complete the cluster in a timely fashion and to complete the online requirements to complete the process.

5 DE Reg. 2297 (06/01/02)

8 DE Reg. 73 (07/01/04)

5.0 Procedures for Requalification of a Cluster

~~5.1 The cluster provider may submit a proposal for activities for requalification to update an individual educator's skills and knowledge acquired in an approved cluster to the Professional Development and Associated Compensation Committee for review. The Professional Development and Associated Compensation Committee may recommend to the Standards Board approval of activities for requalification of a cluster for a period not to exceed five (5) years. The Standards Board and the State Board shall review and approve all requalification requirements.~~

~~5.2 The proposal for requalification activities of an approved cluster must include activities which are at least as rigorous as the original activities of the cluster and shall include, but are not limited to, the following:~~

~~5.2.1 The planned activities required to update the skills and knowledge acquired.~~

~~5.2.2 The number of hours of engagement the participant must participate in to be eligible for requalification of a salary supplement. The number of hours of engagement for the requalification of a cluster must be the same level as the original cluster, unless the provider submits requalification activities for a lesser percentage (i.e., a 4% cluster requalifies as a 2% cluster).~~

~~5.2.3 The specific skills and knowledge that will be updated or requalified and how such activities will directly impact students in the classroom.~~

~~5.3 All proposals for requalification activities must be reviewed by the Professional Development and Associated Compensation Committee, and approved by the Standards Board and the State Board.~~

~~**8 DE Reg. 73 (07/01/04)**~~

6 5.0 Procedures for Reauthorization of Approved Clusters

~~6 5.1 Approval of a cluster is valid for five (5) years from the date of State Board approval. A provider of a cluster may apply for reauthorization of a cluster by submitting an application for reauthorization to the Professional Development and Associated Compensation Committee, which shall review the application and, if appropriate, forward a recommendation to the Standards Board and the State Board for approval. Reauthorization approval of a cluster shall be for a period of five (5) years.~~

~~6 5.2 Cluster developers providers shall, when applying for reauthorization, provide the Professional Development and Associated Compensation Committee with an evaluation of the effectiveness of a cluster in achieving the stated goals. The evaluation shall include evidence of a positive impact on educators' skills and knowledge and student learning. Evaluation reports shall be submitted on the form provided by the Standards Board.~~

~~**8 DE Reg. 73 (07/01/04)**~~

7 6.0 Revocation of Approval of a Cluster

7 6.1 Cluster applications are approved for a period of five years from the date of State Board approval. The Standards Board may, however, revoke the approval of a cluster at any time during the five year period of approval for good cause. "Good cause" includes, but is not limited to:

7 6.1.1 Failure on the part of the provider to complete the delivery of a cluster; or

7 6.1.2 Failure of the provider to submit evidence of completers to DOE; or

7 6.1.3 Evidence, as supplied by participant evaluation and verified by the Professional Development and Associated Compensation Committee, of failure to provide content and activities as set forth in the approved application.

7 6.1.4 Other conduct which negatively impacts the ability of educators to gain new knowledge and skill, such as misrepresentation of the cluster content on the application.

8 DE Reg. 73 (07/01/04)

8 7.0 Responsibility Assignments

8 7.1 The Standards Board shall, on no less than an annual basis, submit to the State Board a list of specific responsibility assignments for approval as the basis for awarding responsibility salary supplements.

8 7.2 Responsibility assignments shall be:

8 7.2.1 Focused on school improvement issues that impact student achievement;

8 7.2.2 Supported by high quality, targeted professional development, and

8 7.2.3 Academic in nature.

8 7.3 In order to qualify for a responsibility assignment salary supplement, an educator shall have completed the state approved training program for the position, or, in the absence of a training program, shall meet the criteria set forth for the position by the Standards Board or local district, charter school, or other employing authority, and shall provide state and district approved levels of service, participate in designated activities throughout the period of responsibility, and document the satisfactory fulfillment of the specified responsibility assignment.

8 7.4 Extra responsibility salary supplements may be renewed.

5 DE Reg. 2297 (06/01/02)

8 DE Reg. 73 (07/01/04)

9 8.0 Approval of Professional Development Clusters and Responsibilities

9 8.1 The Standards Board's Standing Committee on Professional Development and Associated Compensation shall provide the Standards Board with recommendations for approval of professional development clusters, reauthorized clusters, ~~re-qualification activities~~, and responsibility assignments in accordance with this regulation.

9 8.2 The Standards Board shall examine the proposed lists and previously approved lists of clusters to evaluate the system of professional development to determine its overall balance and accessibility.

9 8.3 If approved by the Standards Board, the lists of professional development clusters, reauthorized clusters, ~~re-qualification requirements~~ and responsibility-assignments shall be forwarded to the State Board with a recommendation for approval.

9 8.4 Each district, charter school or other employing authority shall notify educators at least annually, in writing, of the clusters it disapproves from the State Board approved list of knowledge and skills clusters.

8 DE Reg. 73 (07/01/04)

40 9.0 Educators' Eligibility for Salary Supplements

40 9.1 Skills and Knowledge Salary Supplements

40 9.1.1 The provider will present an educator who satisfactorily completes an approved cluster with a certificate of completion to verify eligibility for a salary supplement. The certificate shall certify the knowledge and skills acquired and demonstrated by the educator.

40 9.1.2 After completing the entire cluster, the cluster provider shall submit documentation to the Department certifying that the educator fulfilled the requirements of the cluster's design.

9.1.3 Educators may re-qualify for an additional salary supplement by successfully completing their cluster provider's new subsequent approved cluster. Educators may receive the awarding of additional salary supplements for other approved clusters for gaining knowledge and skills that lead to more effective instruction.

pursuant to Section 11 of this regulation.

~~40~~ 9.2 Responsibility Assignments: An educator shall provide the local district, charter school or other employing authority with such information as may be required to enable the local district, charter school or other employing authority to verify that the educator has fulfilled the requirements of § 7.3 of this regulation.

8 DE Reg. 73 (07/01/04)

44 10.0 Payment of Salary Supplements-

44 10.1 Salary Supplements for Clusters

10.1.1 Knowledge and skills clusters related to new technologies, curriculum adoptions, and short term strategies shall have a base salary supplement duration of five (5) years.

~~44~~ 10.1.4 2 Salary supplements earned by educators who are paid in accordance with the provisions of 14 **Del.C.** §1305 as a result of completion of an approved knowledge and skills cluster shall be effective the first of the month following receipt by the Department of satisfactory completion of a cluster, and shall be paid as part of the educator's salary for the duration of the time approved for the cluster by the Standards Board and the State Board. The salary supplement shall be based on the Delaware educators' salary schedule: 14 Del.C. §1305 (a-b). All applications for a salary supplement for the current fiscal year (July 1 to June 30) must be received in the Office of Professional Accountability no later than June 1. Applications received after June 1 will be approved effective the first day of the next fiscal year. No educator is entitled to payment for the same cluster more than once.

44 10.2 Salary Supplements for Extra Responsibility Assignments

~~44~~ 10.2.1 Salary supplements earned by educators who are paid in accordance with the provisions of 14 **Del.C.** §1305 as a result of fulfilling extra responsibility assignments shall be effective the first of the month following receipt by the Department of documentation from the school district, charter school, or other employing authority of satisfactory completion of the duties associated with the extra responsibility assignment, and shall be paid annually as a single payment or as an additional salary amount spread evenly across an educator's contract period.

8 DE Reg. 73 (07/01/04)

42 11.0 Limits on Salary Supplements

Salary supplements paid to an educator paid in accordance with the provisions of 14 **Del.C.** §1305 shall not exceed 15% of the State share of the educator's salary.

8 DE Reg. 73 (07/01/04)

8 DE Reg. 1137 (02/01/05)

PROFESSIONAL STANDARDS BOARD

Statutory Authority: 14 Delaware Code, Section 122(d) (14 **Del.C.** §122(d))
14 **DE Admin. Code** 1516

Education Impact Analysis Pursuant To 14 **Del.C.** Section 122(d)

1516 Standard Certificate

A. Type of Regulatory Action Requested

Amendment to Existing Regulation

B. Synopsis of Subject Matter of Regulation

The Professional Standards Board, acting in cooperation and collaboration with the Department of Education, seeks the consent of the State Board of Education to amend 14 **DE Admin. Code** 1516 Standard Certificate. It is necessary to amend this regulation in order to expand the provision for the Department's ability to not act on an application for certification if the applicant is under an official investigation.

Persons wishing to present their views regarding this matter may do so in writing by the close of business

on March 3, 2007 to Mr. Charlie Michels, Executive Director, Delaware Professional Standards Board, The Townsend Building, 401 Federal Street, Dover, Delaware 19901. Copies of this regulation are available from the above address or may be viewed at the Professional Standards Board Business Office.

C. Impact Criteria

1. Will the amended regulation help improve student achievement as measured against state achievement standards? The amended regulation addresses student achievement by establishing standards for the issuance of a standard certificate to educators who have acquired the prescribed knowledge, skill and/or education to practice in a particular area, to teach a particular subject or to instruct a particular category of students to help ensure that students are instructed by educators who are highly qualified.

2. Will the amended regulation help ensure that all students receive an equitable education? The amended regulation helps to ensure that all teachers employed to teach students meet high standards and have acquired the prescribed knowledge, skill and/or education to practice in a particular area, to teach a particular subject or to instruct a particular category of students.

3. Will the amended regulation help to ensure that all students' health and safety are adequately protected? The amended regulation addresses educator certification, not students' health and safety.

4. Will the amended regulation help to ensure that all students' legal rights are respected? The amended regulation addresses educator certification, not students' legal rights.

5. Will the amended regulation preserve the necessary authority and flexibility of decision-makers at the local board and school level? The amended regulation will preserve the necessary authority and flexibility of decision makers at the local board and school level.

6. Will the amended regulation place unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels? The amended regulation will not place unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels.

7. Will decision making authority and accountability for addressing the subject to be regulated be placed in the same entity? The decision-making authority and accountability for addressing the subject to be regulated rests with the Professional Standards Board, in collaboration with the Department of Education, and with the consent of the State Board of Education.

8. Will the amended regulation be consistent with and not an impediment to the implementation of other state educational policies, in particular to state educational policies addressing achievement in the core academic subjects of mathematics, science, language arts and social studies? The amended regulation will be consistent with, and not an impediment to, the implementation of other state educational policies, in particular to state educational policies addressing achievement in the core academic subjects of mathematics, science, language arts and social studies.

9. Is there a less burdensome method for addressing the purpose of the amended regulation? 14

Del.C. requires that we promulgate this regulation.

10. What is the cost to the state and to the local school boards of compliance with the adopted regulation? There is no additional cost to local school boards for compliance with the regulation.

1516 Standard Certificate

(Break in Continuity of Sections)

3.0 Standard Certificate

The Department shall issue a Standard Certificate to an educator who holds a valid Delaware Initial, Continuing or Advanced License; or Limited Standard, Standard, or Professional Status Certificate issued prior to August 31, 2003, who has met the following requirements:

3.1 Acquired the prescribed knowledge, skill or education to practice in a particular area, to teach a particular subject or to instruct a particular category of students by:

3.1.1 Obtaining National Board for Professional Teaching Standards certification in the area, subject, or category for which a Standard Certificate is ~~requested~~ appropriate; or

3.1.2 Meeting the requirements set forth in the relevant Department or Standards Board regulation governing the issuance of a Standard Certificate in the area for which a Standard Certificate is sought; or

3.1.3 Graduating from an NCATE specialty organization recognized educator preparation program or from a state approved educator preparation program, where the state approval body employed the appropriate NASDTEC or NCATE specialty organization standards, offered by a regionally accredited college or university, with a major or its equivalent in the area of the Standard Certificate requested, or

3.1.4 Satisfactorily completing the Alternative Routes for Licensure and Certification Program, the Special Institute for Licensure and Certification, or such other alternative educator preparation programs as the Secretary may approve; or

3.1.5 Holding a bachelor's degree from a regionally accredited college or university in any content area and for applicants applying after June 30, 2006 for their first standard certificate, satisfactory completion of fifteen (15) credits or their equivalent in professional development related to their area of certification, of which at least six (6) or their equivalent credits must focus on pedagogy, selected by the applicant with the approval of the employing school district or charter school which is submitted to the Department; and

3.2 For applicants applying after December 31, 2005, where a Praxis™ II examination in the area of the Standard Certificate requested is applicable and available, achieving a passing score as established by the Standards Board, in consultation with the Department and with the concurrence of the State Board, on the examination; or

3.3 Meeting the requirements for licensure and holding a valid and current license of certificate from another state in the area for which a Standard Certificate is requested; or-

~~3.3.1 The Department shall not act on an application for certification if the applicant is under official investigation by any state or local authority with the power to issue educator licenses or certifications, where the alleged conduct involves allegations of immorality, misconduct in office, incompetence, willful neglect of duty, disloyalty, or falsification of credentials, until the applicant provides evidence of the investigation's resolution.~~

3.4 Meeting the requirements for a Meritorious New Teacher Candidate Designation adopted pursuant to 14 **Del.C** §1203.

~~3.5 If additional criteria are imposed by a specific regulation in the area for which a Standard Certificate is sought, the additional requirements must also be met.~~

7 DE Reg. 161 (8/1/03)

7 DE Reg. 629 (11/1/03)

7 DE Reg. 1004 (2/1/04)

7 DE Reg. 1742 (6/1/04)

10 DE Reg. 97 (7/1/06)

(Break in Continuity of Sections)

6.0 Application Procedures for License Holders

~~6.1 If an applicant holds a valid Initial, Continuing, or Advanced Delaware License; or a Limited Standard, Standard or Professional Status Certificate issued prior to August 31, 2003 and is requesting additional Standard Certificates, only that documentation necessary to demonstrate acquisition of the prescribed knowledge, skill or education required for the additional Standard Certificate requested is required; and,~~

~~6.2 If additional criteria are imposed by a specific regulation in the area for which a Standard Certificate is sought, the additional requirements must also be met; and,~~

~~6.3 Notwithstanding any provision to the contrary herein, or in any Department or Standards Board content area, subject or category standard certificate regulation (i.e., 14 DE Admin. Code, Ch. 15, et. al.), the Department shall not act on an application for certification if the applicant is under official investigation by any national, state or local authority with the power to issue educator licenses or certifications, where the alleged conduct involves allegations of immorality, misconduct in office, incompetence, willful neglect of duty, disloyalty or falsification of credentials, until the applicant provides evidence of the investigation's resolution.~~

7 DE Reg. 161 (8/1/03)

7 DE Reg. 629 (11/1/03)

7 DE Reg. 1742 (6/1/04)

10 DE Reg. 97 (7/1/06)

***Please Note:** As the rest of the sections were not amended, they are not being published. A complete set of the rules and regulations for the Department of Education is available at: <http://www.state.de.us/research/AdminCode/title14/index.shtml#TopOfPage>

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

PUBLIC NOTICE

Long Term Care Medicaid

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend existing rules in the Division of Social Services Manual (DSSM) to comply with the transfer of assets provisions mandated by the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171).

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy and Program Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 (new fax number) by March 2, 2007.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSED AMENDMENT

Statutory Authority

Deficit Reduction Act of 2005 (Public Law 109-171), enacted on February 8, 2006

Background

On February 8, 2006, the Deficit Reduction Act (DRA) of 2005 was signed into law. The DRA made changes to certain Medicaid eligibility provisions in Section 1917(c)(1)(B)(i) of Social Security Act affecting Long Term Care services and supports.

Summary of Proposal

The DRA contains a number of provisions necessitating changes to Delaware rules. This regulatory action incorporates the mandatory provisions as it relates to: 1) *Purchase of Promissory Notes, Loans, or Mortgages*; and, 2) *Purchase of Life Estates*.

1) Purchase of Promissory Notes, Loans, or Mortgages

Section 6016(c) of the DRA requires that when the long-term care Medicaid applicant/recipient holds the promissory notes, loans and mortgages, that they be actuarially sound, make payments in equal amounts with no deferral or balloon payments and prohibit cancellation of the balance at the death of the lender. Otherwise, the note, loan or mortgage may be considered a transfer of assets and the applicant/recipient will not be eligible for long-term care Medicaid services.

If the above criteria are not met, the purchase of the promissory note, loan or mortgage will be treated as a transfer of assets and the applicant/recipient will not be eligible for long-term care Medicaid services.

2) Purchase of Life Estates

Section 6016(d) of the DRA provides that a life estate in a home property may be an excluded resource

providing the purchaser reside in the home for a period of at least one (1) year after the date of purchase. The Division of Social Services Manual (DSSM) was using the terms "Life Time Rights" and "Life Estates" interchangeably. The updated rules show the differentiation between these two terms.

The provisions of the DRA discussed above are effective for payments made under Title XIX of the Act for calendar quarters beginning on April 1, 2006, and thereafter.

**DMMA PROPOSED REGULATION #07-02
REVISIONS:**

20320.1.5 Lifetime Rights

In the case of lifetime rights the individual may live in or use the property during their lifetime, but ~~cannot sell without the consent of the heirs~~ has no ownership rights. The individual merely has the right to live in the property.

(Break in Continuity of Sections)

20320.2.2 ~~Lifetime Rights~~ Life Estates

~~Lifetime rights (life estates) Life Estates conveys to the individual certain property rights for the duration of his or her life, or someone else's life. A life estate is a form of legal ownership and is usually created through a deed or will. Generally, a life estate entitles the owner of the life estate to possess, use, and obtain profits from the property as long as he or she lives. However, actual ownership of the property has passed to another individual. The owner of a life estate can sell the life estate but does not have title to the property. Document ownership of a life estate with a copy of the deed or will. Life Estate is an ownership interest in real property. The right of ownership exists for the lifetime of an individual(s). Upon the death of the individual(s) the ownership passes to the "remainderman." A life estate may be sold or otherwise transferred. As per the Deficit Reduction Act of 2005 (DRA), effective 4/1/06, a life estate in a home property may be an excluded resource providing the purchaser resides in the home for a period of at least 1 year after the date of purchase and continues to live in the property.~~

20320.2.2.1 Non-Home Property

A life estate in nonhome property must be counted as a resource. ~~A life estate in home property may be an excluded resource~~ See section 20320.3 - Principal Place of Residence Section.

20320.2.2.2 Transfer of Assets

In a life estate transaction, a transfer of assets is involved when the applicant or spouse, as owner of the property, transfers ownership of that property to another individual while retaining lifetime rights. This transfer is for less than fair market value whenever the value of the transferred asset (i.e. ownership of the property) is greater than the value of the life estate. See Section 20350 - Transfer of Assets to determine whether a penalty is assessed because of a life estate transaction. In addition, a transfer of assets has occurred when an individual purchases a life estate in another individual's home when the purchaser has not lived there for at least 1 year.

20320.2.2.3 Calculations of Life Estate Value

To calculate the value of the life estate, use the life estate table. Determine the value of the life estate by multiplying the current market value of the property by the life estate decimal that corresponds to the life estate owner's age.

See ~~PROCEDURES FOR IMPLEMENTATION OF ELIGIBILITY RULES 20350~~ Life Estate and Remainder Interest Table 20350

20320.2.2.4 Life Estate with Powers

Under a life estate with powers, the owner of the property creates a life estate for himself or herself, retaining the power to sell the property, with a remainder interest to someone else such as a child. Since the life estate holder retains the power to sell the property, its value as a resource is the property's full equity value (unless it is an otherwise excludable resource).

20320.2.2.5 Remainder Interest

When the owner of property gives it to one party in the form of a life estate, and designates a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property. Determine the value of a remainder interest by multiplying the current market value of the property by the remainder interest decimal that corresponds to the individual's age.

See ~~PROCEDURES FOR IMPLEMENTATION OF ELIGIBILITY RULES~~ 20350 Life Estate and Remainder Interest Table

20320.2.2.6 Rebuttal

The applicant may be given an opportunity to rebut the value placed on the life estate. The rebuttal must include an estimate from a disinterested, knowledgeable source (such as a broker or appraiser) showing that the value is less than our determination or that the property has no marketable value.

20330.3 Promissory Notes, Loans and Property Agreements

A loan is an advance from a lender to a borrower that the borrower must repay, with or without interest. Loan proceeds are not income to the borrower because of the borrower's obligation to repay. Any portion of the borrowed funds that the borrower does not spend is a countable resource if retained into the month following the month of receipt.

If the Medicaid applicant is the owner of a promissory note, loan, or property agreement (mortgage), assume the value of the agreement is its outstanding principal balance, ~~unless the individual furnishes reliable evidence that it has a current market value of less than that or no current market value at all. If the note, loan or mortgage is not salable, it has no current market value.~~

If the outstanding principal balance plus other countable resources exceeds the resource limit, inform the individual that ~~DSS/Medicaid~~ DMMA will use the outstanding principal balance in determining resources unless the individual submits within 30 days the following information.

a. ~~evidence of a legal bar to the sale of the agreement~~

b. ~~an estimate from a knowledgeable source (financial institution, bank, real estate broker) showing the current market value of the agreement is less than its outstanding principal balance. The estimate must show the name, title and address of the source.~~

As per the Deficit Reduction Act of 2005 (DRA), effective 4/1/06, the promissory note, loan, or mortgage will be considered a transfer for less than fair market value unless-

- The repayment term is actuarially sound;
- Payments are made in equal amounts during the term of the loan with no deferral or payments and no balloon payments; and
- The promissory note, loan or mortgage prohibits the cancellation of the balance upon the death of the lender.

In determining the amount of the asset transfer, the value of the note, loan or mortgage is the outstanding balance

due at the date of the individual's application for Medicaid coverage of services listed in section 1917(c)(1)(C) of the Act.

Payments received against the principal balance are not income. They are conversion of a resource. The portion of the payment which represents interest is unearned income.

The SSA Life Expectancy Table can be found at www.ssa.gov/OACT/STATS/table4c6.html.

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

PUBLIC NOTICE

Long Term Care Program DSSM 20330.7 - U.S. Savings Bonds

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend a rule in the Division of Social Services Manual (DSSM) used to determine financial eligibility.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy and Program Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 (new fax number) by March 2, 2007

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF THE PROPOSED CHANGE

CMS issued a letter to Region I, dated February 2, 2004, which gave clarifying guidance on the point at which U.S. Savings Bonds are an available resource. Previous language suggested that the bonds would not be an available resource until the bonds were submitted to the Office of Public Debt and check issued. The letter cited, suggests that because the bonds can be redeemed due to hardship, that they are immediately available. The guidance from CMS approved valuation of United States savings bonds as a resource beginning on the date of purchase unless individuals have requested and been denied a hardship waiver from the United States Department of the Treasury, Bureau of the Public Debt.

DMMA PROPOSED REGULATION #07-04

REVISIONS:

20330.7 U.S. Savings Bonds

U.S. Savings Bonds are obligations of the Federal Government. They are not transferable and can only be sold back to the Federal Government. Normally, they cannot be redeemed for six months after the issue date specified on the face of the bond. For Series EE and I Savings Bonds, the redemption period has been extended to 12 months. They are not resources during the retention period. They become resources (not income) as of the 7th month or 13th. A bond may not roll over or renew in order to prolong the minimum retention period. Actual redemption (converting to cash) of one bond is required before purchasing a new bond. However, the U.S. Treasury regulation authorizes the Commission of Public Debt to waive the regulatory provisions pertaining to U.S.

Savings Bonds including the redemption period in order to "relieve any person or persons of unnecessary hardship." A request for a refund because the person now requires Nursing Home care and so needs the funds used to purchase the bonds may constitute a hardship. A written request to the Commissioner of Public Debt requesting a waiver to the redemption period is all that is required. The bondholder may simultaneously tender the bond(s) for redemption. If the Treasury receives the bond(s) and grants the waiver, it will issue the individual a check. ~~At that point, the individual would have a countable resource in the amount of the check. Since bonds are redeemable due to hardship, the redemption value is treated as an available resource.~~

The individual in whose name a U.S. Savings Bond is registered owns it. The Social Security Number shown on a bond is not proof of ownership. The co-owners of a bond (bond titled AND/OR) own equal (50%) shares of the redemption value of the bond. The bond may show an owner followed by POD (proof of death) and another name. This is a survivorship type of bond. The name of the first individual owns 100% of the bond. The second individual will own 100% of the bond upon the death of the first individual.

Physical possession of a U.S. Savings Bond is a requirement for redeeming it. This is true for sole or joint ownership. If an individual alleges that he or she cannot submit a bond because a co-owner or other individual will not relinquish physical possession of the bond, obtain a signed statement from the co-owner or the other individual that he or she: has physical possession of the bond; will not allow the applicant to cash the bond; and if co-owner, will not cash the bond and give the applicant his or her share.

The Table of Redemption Values for U.S. Savings Bonds is used to determine the value of a bond. These are available from a local bank. The bank will need the series, denomination, date of purchase or issue date. After the mandatory 6-month retention period, the value of a series H or HH bond is its face value.

Office of Public Debt
Buffalo Branch, FRB of NY
Fiscal Services Division
PO Box 961
Buffalo, NY 14240-0961
www.publicdebt.treas.gov

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 Del.C. §512)

PUBLIC NOTICE

DSSM 20910.1 Institutionalized Spouse

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend a rule in the Division of Social Services Manual (DSSM) used to determine financial eligibility for medical assistance.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy and Program Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 (new fax number) by March 2, 2007.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSED CHANGE

Citation

States Medicaid Manual 3710, *Special Post-Eligibility Process for Institutionalized Persons with Community Spouses*

Summary of Proposed Change

DSSM 20910.1: The Centers for Medicare and Medicaid (CMS) pointed out an error in the Division of Social Services Manual (DSSM). The error would have disallowed a spousal calculation for a community spouse if they were receiving Medicaid through Home and Community based Services.

DMMA PROPOSED REGULATION #07-03

REVISION:

20910.1 Institutionalized Spouse

An individual who is in a medical institution or nursing facility and is married to a spouse who is not in a medical institution or nursing facility. ~~and who is not receiving HCBS.~~

DIVISION OF PUBLIC HEALTH

Statutory Authority: 16 Delaware Code, Section 122(1), (3)a and 11(8)
(16 Del.C. §122(1), (3)a and 11(8))

PUBLIC NOTICE

4104 Conrad State 30/J-1 Visa Waiver Program

The Department Health and Social Services is proposing amendments to the State of Delaware Regulations Governing the Conrad State 30/J-1 Visa Waiver Program. Originally adopted on January 11, 2000, these regulations set forth requirements and procedures for an international medical graduate (IMG) requesting State support for a J-1 visa waiver.

NOTICE OF PUBLIC HEARING

Health Systems Management Section, under the Division of Public Health, Department of Health and Social Services (DHSS), will hold a public hearing to discuss the proposed revisions to the State of Delaware Regulations Governing the Conrad State 30/J-1 Visa Waiver Program. The public hearing will be held on February 23, 2007, at 2:00 p.m. in the Felton-Farmington Room, located in the Delaware Department of Transportation Building, 800 Bay Road, Dover, Delaware.

Copies of the proposed regulations are available for review by calling the Health Systems Management Section at (302) 741-2960.

Anyone wishing to present his or her oral comments at this hearing should contact Mr. David Walton at (302) 744-4700 by February 22, 2007. Anyone wishing to submit written comments as a supplement to or in lieu of oral testimony should submit such comments by March 2, 2007 to:

David Walton, Hearing Officer
Division of Public Health
417 Federal Street
Dover, DE 19901
Fax 302-739-6659

Summary of Changes to Regulations Governing the Conrad State 30/J-1 Visa Waiver Program

- Institution of application fees in accordance with Delaware law.
- Requirement for letters of support from community members without financial interest in approval of

the application - one from an elected public official, one from a medical professional and one from an individual representing the patient population. Removal of the requirement that applicants submit letters of support from a local public health official.

- Prohibition of non-complete/restrictive covenant clauses in employment contracts.
- Changes in the timelines for receipt and review of applications to more closely coincide with the provider recruitment process as it pertains to the recruitment of medical residents and to reduce the wait time between approval of a physician application and the employment start date.

4104 Conrad State 30/J-1 Visa Waiver Program

1.0 Purpose

This document will specify the procedures to be used by the Delaware Health and Social Services (DHSS) in administering the Conrad State 30/J-1 Visa Waiver Program (Program).

2.0 Authority

~~16 Del.C., Ch. 1, Sec. 122, Public Law 103-416 United States Code~~

2.0 Background

International medical graduates (IMG) completing their graduate medical education in the United States under a J-1 Visa are required to return to their country of nationality for at least two years before reentering the United States. Acting as an interested state agency, DHSS may make a recommendation to the U.S. Department of State, Bureau of Consular Affairs Waiver Review Division (DOS) to, in turn, recommend that the U.S. Citizenship and Immigration Services (UCIS) waive the home residence requirement for up to thirty (30) J-1 physicians annually (this includes five J-1 flex waivers to be used in areas that are not federally designated as a Health Professional Shortage Area (HPSA), but nevertheless have been identified by the state as being underserved. Additionally, a J-1 physician may apply directly to the United States Department of Agriculture (USDA) for a J-1 visa waiver. In order to receive a letter of support for the J-1 physician applicant from DHSS, however, applications must first meet requirements, described herein.

3.0 Policy Statements

3.1 DHSS is committed to ensuring that quality health care is available to all residents of the State of Delaware. In an effort to ensure adequate medical services are provided in underserved areas, DHSS has elected to take advantage of the Conrad State 30/J-1 Visa Waiver Program.

3.2 Under this program, DHSS has established state-specific procedures that require sponsoring sites to submit a Site Application. This application consists of 1) a needs assessment, 2) proof that the sponsoring site has unsuccessfully attempted over a six month period to hire a physician with United States citizenship, 3) three letters of support from community leaders ~~and local public health officials~~ and/or leaders without financial interest in the practice site who reside in the practice site's service area, 4) strategy for long-term and short-term retention, 5) sponsoring site waiver agreement, 6) non-refundable processing fee of \$200, and 7) a site application form.

3.3 The needs assessment must establish and document that a particular need exists within the sponsoring site's service area before the site will be approved to hire a J-1 physician under the Conrad State 30/J-1 Visa Waiver Program. The onus to establish the need rests solely with the sponsoring site.

3.4 The Site Application will be reviewed and approved or disapproved by a Board. DHSS will provide written notice to the site of the application's approval/disapproval. A J-1 visa waiver application on behalf of a particular J-1 physician may not be submitted until the sponsoring site has been approved. J-1 visa waiver applications will only be accepted from J-1 physicians who have signed a contract with a *pre-approved* site.

3.5 DHSS will submit recommendations to the DOS on behalf of qualified J-1 physician applicants who agree to practice medicine full-time at a pre-approved sponsoring site for a minimum of three years in a federally designated Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA) of Delaware with a *pre-approved* site.

3.6 DHSS participation in the Conrad State 30/J-1 Visa Waiver Program is completely discretionary and voluntary. DHSS may elect not to participate in the Program at any time. The submission of a complete waiver package does not ensure DHSS will recommend a waiver in all instances. No more than 30 applications will be approved each fiscal year. DHSS reserves the right to recommend or decline any request for a waiver.

3.7 The Bureau of Health Planning and Resources Management within the Delaware Division of Public Health shall charge a non-refundable processing fee of \$200 to each sponsoring site submitting a Site Application at the time the application is submitted. A non-refundable processing fee of \$250 shall be charged to each pre-approved site to process the waiver request application for each J-1 physician that the site plans to employ. The check is to be made payable to the State of Delaware, and mailed to the attention of the Bureau at the following address:

Conrad State 30 Program Manager
Delaware Division of Public Health
Health Systems Development Branch
655 South Bay Road, Suite 206
Blue Hen Corporate Center
Dover, Delaware 19901

3.8 DHSS reserves the right to bar sites and/or physicians found to be non-compliant with program policies from future program participation.

3.9 This policy applies in full to any waiver submitted on behalf of a J-1 physician to be employed in Delaware.

4.0 DHSS Duties and Responsibilities

The Health Systems Development Branch Management Section of the Delaware Division of Public Health (DPH) has primary responsibility within DHSS for processing J-1 visa waivers. DHSS serves as the "interested state agency" with the Director of Public Health having the authority to sign the recommendations. Applications must be processed in the best interest of the health care needs of Delawareans.

5.0 Applicability

5.1 These procedures apply to the following:

- All J-1 physicians seeking a J-1 visa waiver under PL 103-416 for employment in Delaware.
- All sponsoring sites seeking approval to hire a J-1 physician under the J-1 Visa Waiver program.
- All DHSS employees processing J-1 visa waivers under PL 103-416.

6.0 Application Process

6.1 Sponsoring Site Pre-Approval Application Requirements

The Site Application (see Appendix A for Application forms) must, at a minimum, include the following:

6.1.1 Site Application Form

6.1.1.1 **Sponsoring Site:** Provide the name, address, county, telephone number, fax number and the e-mail address of site requesting approval to hire a J-1 physician. Also, the site must specify whether it is a for-profit or not-for-profit business.

6.1.1.2 **Practice Site:** Provide the name, address and county of actual practice site(s) where the requested J-1 physician would practice, if different from the primary location of the sponsoring site.

6.1.1.3 **Recruitment Contact:** Provide the name, address, county, telephone number, fax number and e-mail address of the individual responsible for physician recruitment.

6.1.1.4 **Site Data Regarding Active Clients:** Provide the total number of active patients at the practice site in the previous calendar year. Indicate total patients, as applicable, for primary care, specialty care and mental health services. Provide pro-rated or estimated annual totals if the site was not operational for the entire previous calendar year. For new sites, estimate the number of patients anticipated for the next year. Of the total number of patients, provide the percentage of all current patients, broken out by given age groups, making payment by conventional insurance plans, Medicare, Medicaid or on a sliding fee scale. A copy of the sliding fee scale must be submitted.

6.1.1.5 Sites approved to participate in the Conrad State 30/J-1 Visa Waiver Program must also participate in state programs for the uninsured/under insured such as the Community Healthcare Access Program (CHAP), the VIPII provider network, and, if appropriate other charitable programs. Sponsoring sites must

verify that they will enroll in the VIPII Program within 30 days of site approval (if they are not already network members). To enroll in the program, call Wheeler and Associates at 302-335-1560.

6.1.1.6 **Staffing Levels:** Provide the total number of budgeted full-time equivalent providers currently on staff. Also include the number of J-1 physicians requested, by specialty, and the projected hire date of each.

6.1.1.7 **Practice Site Hours of Operation:** Indicate the normal operating hours of the practice site(s) by the days of the week. If hours of operation vary by practitioner, please specify.

6.1.1.8 **Proposed J-1 Physician Weekly Work Schedule:** Indicate the proposed weekly work schedule of the proposed J-1 physician(s). Include the number of hours (with start and end times) and the location (hospital/practice site(s)). The schedule must indicate the amount of time the J-1 physician is actually providing services; do not include travel or on-call time.

6.1.2 Needs Assessment

Sponsoring sites are encouraged to work with their local hospital to complete the needs assessment. A comprehensive, data driven needs assessment must be completed, which, at a minimum, includes the following:

6.1.2.1 Description of the service area in which the sponsoring site's patients are located.

6.1.2.2 Geographic Service Area Health Resource Inventory. Description of the other health care resources located within the same service area including physicians (by specialty), hospitals, clinics, urgent care centers and any other available outpatient care facilities. Also include the location of the nearest available source of outpatient based services, which offers a sliding fee scale to patients with limited financial resources and that provides services similar to those that are being provided by the requested J-1 physician. Using public transportation as the mode of travel, indicate the distance and travel time to that site.

6.1.2.3 Documentation that the sponsoring site's service area is located within a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA). Please indicate the following: HPSA Type(s), HPSA Service Area Number, HPSA FIPS State/County Code and the sponsoring site's primary service area (by City/County).

6.1.2.4 Documentation of a shortage in the defined service area for the particular physician specialty being requested under the J-1 Visa Waiver Program.

- Provide statistics demonstrating the need for a specialty and/or sub-specialty in the sponsoring site's service area.
- Document that the specialty and/or sub-specialty is not available to the underserved population in the service area.
- Describe how a J-1 physician would be used to meet the needs of the underserved population in the service area. Indicate if unique qualifications, such as cultural match or experience with the service area's underserved population, are sought to meet a particular need.

6.1.3 Retention

The sponsoring site must provide **thorough** written documentation of plans to retain the J-1 physician in the service area upon completion of the three-year practice obligation. Specifically, this plan must include short and long-term strategies that will not only keep the physician in the service area, but also will encourage the physician to continue to practice the specialty for which he/she was hired including but not limited to malpractice insurance, partnership opportunities, if applicable, annual and sick leave, competitive salary and salary increases and a health and/or benefits package. The employment contract may not contain any Restrictive Covenants or Non-Compete Clauses.

6.1.4 Contract

6.1.4.1 The employment contract that will be offered to the J-1 physician(s) must be submitted for review to the J-1 Board and at a minimum, include the following:

6.1.4.1.1 Name and address of the sponsoring site.

6.1.4.1.2 Name and address of the location of the sponsoring site's practice. If the J-1 physician will work at more than one site, include the days and hours of practice at each site and a breakdown in the amount of time the physician will practice at each site.

6.1.4.1.3 A statement that the J-1 physician will work not less than four days per week or more than 12 hours in a 24 hour period. The hours must be performed during normal office hours or hours which best meet the needs of the community (e.g. evenings and/or weekends). Travel and on-call time

can not be included.

6.1.4.1.4 A statement that the site will employ the physician on a full-time basis (minimum of 40 hours per week, not including time spent in travel and/or on-call).

6.1.4.1.5 A Statement that the J-1 physician will commence practice within 90 days of receiving a waiver and will practice on a full-time basis for at least three years.

6.1.4.2 The employment contract may not include a restrictive covenant or non-compete clause.

6.1.5 Proof of Failed Recruitment Attempts

The sponsoring site must provide proof that attempts have been made to hire a physician with United States citizenship throughout the past six months to no avail. This section must include a written description of the failed attempts to recruit as well as back up documentation including, but not limited to, medical journal and newspaper advertisements, letters to medical residency programs and/or medical schools, etc. Please state any attempts to gain recruitment support from the hospital within the practice site's geographic service area, and if applicable, indicate effort to use the Delaware State Loan Repayment Program, the National Rural Recruitment and Retention Network (3R Net), and the National Health Service Corp. to recruit a US citizen.

6.1.6 Letters of Support

The sponsoring site must submit at least three letters of support. ~~Two must be obtained from community members and/or leaders in the practice site's service area. One must be obtained from a local public health official (see Appendix B for an approved contact list).~~ from community members without financial interest in the practice site who reside in the site(s) service area. Each letter must indicate the benefits of, or need for, the placement of a J-1 physician with the sponsoring site. At least one letter must be from an elected public official. At least one letter must be from a medical professional. At least one letter must be from an individual representing the patient population.

6.1.7 Sponsoring Site Waiver Agreement

The director or applicant official of the sponsoring site must initial each of the statements indicating agreement to comply with requirements of the Delaware Conrad State 30/J-1 Visa Waiver Program. The form must also be signed and dated to include the title of the applicant official.

6.1.8 Signature

The director or applicant official of the sponsoring site must provide an original, dated application with a live signature (using blue ink). This signature binds the site to the information provided and verifies that the form has been completed with accurate and current information.

6.1.9 Non-refundable processing fee of \$200

6.1.9.1 The director or applying official of the sponsoring site must provide a non-refundable processing fee of \$200 at the time the application is submitted. The check will be made payable to the State of Delaware and mailed to the following address:

Conrad State 30 Program Manager
Delaware Division of Public Health
Health Systems Development Branch
655 South Bay Road, Suite 206
Blue Hen Corporate Center
Dover, Delaware 19901

6.1.9.2 Without payment of the processing fee the application will be deemed incomplete and will not be processed.

6.2 J-1 Physician Application Requirements

6.2.1 Applications will only be accepted from J-1 physician applicants who already have an employment contract with a pre-approved sponsoring site (see section IV above). The completed application must include the original application package and two complete copies. Applicants are also encouraged to submit a complete application in electronic format (CD or e-mail). No more than 30 applications will be approved each federal fiscal year. DHSS reserves the right to recommend or decline any request for a waiver.

6.2.2 The J-1 Physician Application (see Appendix C for application forms) must, at a minimum, include the following:

PROPOSED REGULATIONS

6.2.2.1 Letter from the Director of the Sponsoring Site

The director of a pre-approved sponsoring site must submit a letter requesting a Delaware Health and Social Services (DHSS) recommendation to the U.S. Department of State, Bureau of Consular Affairs Waiver Review Division (DOS) (or other Federal approving agency) that a J-1 physician be given a waiver of the requirement to return to their country of nationality. The letter must include, or attach, each of the following:

6.2.2.1.1 Description of the J-1 physician's qualifications, proposed responsibilities and how his/her employment will meet the unmet health care needs of the medically underserved community.

6.2.2.1.2 If the J-1 physician will be practicing in a HPSA or MUA that is based on a population group, the employer must provide adequate documentation of the medical care that will be provided to this group of patients.

6.2.2.1.3 Confirmation that the sponsoring site and the J-1 physician participates in or applied to participate in the VIPII Program. J-1 physicians must apply to participate in the program within 30 days of executing an employment contract with a sponsoring site. To enroll in the program, call Wheeler and Associates at 302-335-1560. Once enrolled, the VIPII program manager will notify the J-1 Program manager.

6.2.2.1.4 Certification that the J-1 physician will provide medical care services to Medicare, Medicaid and medically underserved patients, without discrimination based upon ability to pay for such services (i.e. self-pay, sliding fee scale, charity care). Enclose a copy of the sliding fee scale or policy for discounting charges.

6.2.2.1.5 Completed Physician Data Sheet (copy enclosed).

6.2.2.1.6 Copy of the J-1 physician's curriculum vitae (CV).

6.2.2.1.7 Evidence of eligibility for a Delaware medical license.

6.2.2.1.8 At least three letters of recommendation from persons familiar with the J-1 physician's work.

6.2.2.1.9 A signed statement from the J-1 physician agreeing to the contractual requirements set forth in Section 214 (k)(1) (B) and (C) of the Immigration and Nationality Act.

6.2.2.1.10 Copies of all IAP-66 forms issued to the J-1 physician seeking the waiver.

6.2.3 Employment Contract

6.2.3.1 The employment contract must be submitted for review to the J-1 Board and at a minimum, include the following:

- Name and address of the sponsoring site.
- Name and address of the location of the sponsoring site's practice. If the J-1 physician will work at more than one site, include the days and hours of practice at each site and a breakdown in the amount of time the physician will practice at each site.
- A statement that the J-1 physician will work not less than four days per week or more than 12 hours in a 24 hour period. The hours must be performed during normal office hours, or hours which best meet the needs of the community (e.g. evenings and/or weekends). Travel and on-call time can not be included.
- A statement that the site will employ the physician on a full-time basis (minimum of 40 hours per week, not including time spent in travel and/or on-call).
- Statement that the J-1 physician will commence practice within 90 days of receiving a waiver and will practice on a full-time basis for at least three years.
- The employment contract may not contain any Restrictive Covenants or Non-Compete Clauses.
- It must include a competitive salary.
- Personal time such as vacation and sick leave must be specified.
- A breakdown of all proposed benefits must be provided.

6.2.3.2 The employment contract may not include a restrictive covenant or non-complete

clause.

6.2.4 Letter of No Objection from Home Country

6.2.4.1 A statement that the physician's home country has no objection to the physician receiving a waiver of the foreign residence requirement must be included if the J-1 physician received funding from his or her home country for medical education or training in the United States. The Certification Regarding Contractual Obligation to Home Country (HD1061F) letter must be submitted directly to the following address by the J-1 physician applicant:

Waiver Review Division
Department of State
Bureau of Consular Affairs, Visa Office
CA/VO/L/W Room, L603
2401 E Street, NW
Washington, DC 20522-0106

6.2.4.2 A copy of this letter must be included in the application packet.

6.2.5 Submission of Payment of the Department of State 'User Fee Required for Waiver Processing'

6.2.5.1 The J-1 physician applicant must provide proof that the \$215.00 processing fee has been sent to the DOS. A copy of the payment (i.e. check or money order) is considered sufficient proof. DHSS will not handle the submission of this fee. The fee must be mailed directly to the DOS at the time the J-1 Visa Waiver Application packet is submitted to DHSS. The submission of the fee must adhere to the following requirements:

6.2.5.1.1 A copy of the Physician Data Sheet and two self-addressed, stamped, legal-size envelopes must accompany the \$215.00 DOS user fee. The applicant's full name, date of birth and social security number must be included on the check or money order, which must be drawn on a bank or other institution located in the United States and made payable to the United States DOS in U.S. currency. If the applicant resides outside the U.S. at the time of application, remittance may be made by bank international money order of foreign draft drawn on an institution in the U.S. and made payable to the United States DOS in U.S. currency. The envelopes will be used to inform the applicant of 1) the case number, which must be included on all future correspondence with DOS, and 2) the approval determination.

6.2.5.1.2 The address to which you must submit these items follows, depending on whether the United States Postal Service or a Courier Service is selected:

If Sending Via United States Postal Service:

US Department of State
Waiver Review Division
Post Office Box 952137
St. Louis, MO 63195-2137

If Sending Via Courier Service:

US Department of State
Waiver Review Division (Box 952137)
1005 Convention Plaza
St. Louis, MO 63101-1200

6.2.6 J-1 Visa Waiver Statements

The J-1 physician applicant must sign and include the enclosed 'J-1 Physician Waiver Statements.'

6.2.7 J-1 Visa Waiver Affidavit and Agreement

The J-1 physician applicant must include a notarized 'J-1 Visa Waiver Affidavit and Agreement.' The document must contain the J-1 physician applicant's live, notarized signature (in blue ink).

6.2.8 J-1 Visa Waiver Application Checklist:

The enclosed checklist must accompany the application. The J-1 physician applicant must initial each item on the checklist as proof and assurance that each item is included in the waiver application packet.

6.2.9 Non-refundable \$250 processing fee

6.2.9.1 A non-refundable processing fee of \$250 shall be charged to each pre-approved site to process the waiver request application for each J-1 physician that the site plans to employ. The check will be made payable to the State of Delaware and mailed to the following address:

Conrad State 30 Program Manager
Delaware Division of Public Health
Health Systems Development Branch
655 South Bay Road, Suite 206
Blue Hen Corporate Center
Dover, Delaware 19901

6.2.9.2 Without payment of the processing fee the application will be deemed incomplete and will not be processed.

7.0 Site Application Evaluation Process

7.1 The Delaware Conrad State 30/J-1 Visa Waiver Program Sponsoring Site Application Review Board (Board) will review and approve or disapprove each Site Application based on its individual merits. Board members must not serve on the review panel for applications submitted by sponsoring sites with which they have either a personal or employment-related conflict of interest. The Board will be comprised of, at least, one member from each hospital in the state located in an underserved area of the state or serving patients from such areas, the Medical Society of Delaware, the Delaware Health Care Commission and DHSS representatives. Additional members may be included at the discretion of the Board.

7.2 Sponsoring Site Application Preliminary Review

7.2.1 A preliminary review of each application will be conducted by the Conrad State 30 Program manager to determine if 1) the sponsoring site is located within a HPSA/MUA and 2) that the following required documentation is completed:

- Sponsoring Site Application
- Detailed Needs Assessment
- Strategy for Long-term and Short-term Retention
- Proof of Failed Recruitment Attempts
- Letters of Support
- Sponsoring Site Waiver Agreement
- Template of the Employment Contract that will be offered
- A non-refundable processing fee of \$200

7.2.2 The preliminary review will be conducted for the purpose of determining the completeness of the application; the specific content provided in each of the components will not be considered. Incomplete applications, as well as applications from a site not located in a HPSA/MUA, will be returned to the sponsoring site ~~immediately~~. A checklist identifying the missing information will be included. Completed applications may be resubmitted at any time prior to ~~the first Monday in December~~ June 30.

7.3 Sponsoring Site Application Review

7.3.1 The Board will convene during the month of August or early September to review the applications submitted before June 30.

7.3.2 Using the Site Application Evaluation (see Appendix D for the form) as a guide, Board members must assign a score to each of the elements on the Site Application Evaluation form.

7.3.3 The following point scale has been assigned to each unique element:

Review Point Scale

Site Application Data	25
Needs Assessment	35

Retention	15
Proof of Failed Recruitment Attempts	15
Letters of Support	10
<hr/> Total	<hr/> 100

7.3.4 The scores from the review elements will be averaged to reach an overall total score for each Board member. The total scores received from each Board member will then be averaged to determine the final score for each site.

7.3.5 Sites will be approved only if:

7.3.5.1 All criteria are met,

7.3.5.2 A final score not lower than a 70 is achieved, and

7.3.5.3 An overall score of at least a twenty-five (25) is achieved on the Needs

Assessment component.

7.4 Timelines

Pre-approved sponsoring sites (whose applications were received by June 30) (~~whose applications were received by the first Monday in December~~) will be eligible to make a contractual offer to a J-1 physician for the following federal fiscal year (beginning October 1st of each year). However, if not all thirty Conrad State 30/J-1 Visa Waiver slots have been used for the current federal fiscal year, pre-approved sponsoring sites may make a contractual offer to a J-1 physician for the current fiscal year and the physician may submit a J-1 visa waiver application packet (see Appendix C for forms) immediately.

7.5 Guidelines for Review of Applications Submitted After June 30

7.5.1 Applications received after the ~~December~~ June 30 deadline will be reviewed to determine if an emergent need (see Glossary for definition of emergent examples) for the placement of a J-1 physician is demonstrated. The application must include a detailed explanation of ~~the reasons~~ that documents why the application was not submitted by June 30 ~~the first Monday in December~~. If not all thirty Conrad State 30/J-1 Visa Waiver slots have been used for the current fiscal year, sponsoring sites deemed by the J-1 Board to have sufficiently demonstrated a true emergent need may make a contractual offer to a J-1 physician immediately upon approval and the physician may submit a J-1 visa waiver application packet (see Appendix C for forms) for the current fiscal year. If all thirty Conrad State 30/J-1 Visa Waiver slots have been used, then approved sponsoring sites must wait until the following federal fiscal year (beginning October 1st of each year) to submit a J-1 physician waiver application.

7.5.2 Sponsoring sites clearly demonstrating a emergent need (see definitions section) that will significantly jeopardize access to care for the applicant site's existing patient population of the applicant site need to document four rather than six months of recruitment efforts. All other recruitment efforts as set forth in these regulations apply.

7.6 Notice of Approval/Disapproval

7.6.1 For those applications received ~~by the first Monday in December~~ by June 30, DHSS will provide written notification of the Site Application's approval or disapproval by ~~February 15th~~ September 15th of each year.

7.6.2 ~~For Applications submitted after the first Monday in December~~ June 30, ~~DHSS will attempt to provide will receive~~ written notification of the Site Application's approval or disapproval within 45 days from the date of receipt of the application by DHSS.

8.0 Timeframes

8.1 Site Application Submission DHSS will accept Site Applications Forms each year through the end of the business day on June 30 ~~the first Monday in December~~. Site Applications submitted after June 30 ~~the first Monday in December~~ will be eligible to receive approval only if 1) DHSS has not used the allotted thirty recommendations for the year and 2) an emergent need for the placement of a J-1 physician is clearly demonstrated. (Please see definitions section of the regulations for definition of emergent need.)

8.2 Site Notification DHSS will notify sponsoring sites in writing of the decision to approve or disapprove their site by ~~September 15th no later than February 15th~~ September 15th of each year. Inquiries regarding the status of

pending applications will not be accepted at any time prior to ~~February 15th~~ September 15th.

8.3 J-1 Visa Waiver Request Submission J-1 Visa Waiver Requests may be submitted with the start of each Federal fiscal year, October 1st.

9.0 Completed Site Applications, Associated J-1 Applications And Processing Fees Must Be Sent To:

Conrad State 30 Program Manager
Delaware Division of Public Health
Health Systems Development Branch
~~P.O. Box 637~~
655 South Bay Road, Suite 206
Blue Hen Corporate Center
Dover, Delaware 19901 ~~49903~~

10.0 Submitting J-1 Physician Waiver Recommendation To Dos

If the J-1 visa waiver request is approved, a cover letter to DOS is prepared by DHSS identifying the J-1 physician applicant and recommending a waiver of the two-year home residence requirement be granted. Upon receipt of the DHSS approval request, DOS will review the application.

11.0 J-1 Physician Applicants Receiving A J-1 Waiver

J-1 physician applicants receiving approval of a J-1 Waiver request must begin work at the sponsoring site within ninety (90) days of notice of approval from DOS.

12.0 Reporting Requirements

12.1 An **annual reporting process** is utilized for each J-1 physician practicing under a waiver to ensure the J-1 physician continues to practice in an underserved area of Delaware for the required three years. Included in this application is a copy of the Annual Practice Forms. The sponsoring site must deliver to DHSS a completed, signed form within thirty (30) days of the anniversary of the J-1 physician's start date. Additional forms may be requested by contacting the J-1 program manager at (302) 741-2960. The annual reporting forms must be submitted for each year of practice obligation. Failure to submit the forms render the sponsoring site non-compliant.

12.2 DHSS will forward an Annual Practice Form (see Appendix E for a sample form) to the sponsoring site within thirty (30) days of the anniversary of the J-1 physician's start date. The sponsoring site must forward the signed, completed Annual Reporting Form to DHSS. An annual reporting form must be submitted for each year of practice obligation.

12.2 Notification of waiver status and commencement of employment contract must be submitted to DHSS upon receipt of written notification of approval from INS. This notification must include the date the three-year obligation commences.

12.3 Contract changes which result in the termination of a contract, a change in practice scope, and/or relocation from a site approved in the application request to a new site must be presented in writing to DHSS at least thirty (30) days prior to the change. All reporting requirements, changes in practice location and/or scope must be submitted to the following:

Conrad State 30 Program Manager
Delaware Division of Public Health
Health Systems Development Branch
~~P.O. Box 637~~
655 South Bay Road, Suite 206
Blue Hen Corporate Center
Dover, Delaware 19901 ~~49903~~

13.0 Exit Interview

Each J-1 physician practicing in Delaware must complete an exit interview within ninety (90) days of completion of his/her three-year obligation, or at such point that the employment contract is terminated by either

the sponsoring site or the J-1 physician. DHSS will conduct the exit interview, which will concentrate on the J-1 physician's experiences in Delaware and their future plans for practicing medicine at the current, or another location.

14.0 J1 Visa Waiver Application Glossary

Department of State, Bureau of Consular Affairs Waiver Review Division (DOS) The Federal agency that reviews the recommendations submitted by interested state agencies on behalf of J-1 physician applicants. In turn, they submit their own recommendation to the Immigration and Naturalization Service for final determination of approval/disapproval.

Emergent Need An emergent need is one that demonstrates an unusual and critical need for the placement of a J-1 physician, such as the death, unexpected departure, or sudden retirement of a clinical physician providing a majority of medical care needs at the sponsoring site. ~~An emergent need includes, but is not limited to, the following: departure, death or retirement of a clinical physician providing a majority of medical care needs.~~

Health Professional Shortage Area (HPSA) An area defined by the Department of Health and Human Services as having a shortage of health care providers.

J-1 Physician An international medical graduate physician completing graduate medical education in the United States under a J-1 Visa. These physicians are required to return to their country of nationality for at least two years before reentering the United States *unless a J-1 Visa waiver is granted.*

Medically Underserved Area An area, as defined by the Department of Health and Human Services, as not having an adequate supply of health care providers.

Practice Site Actual physical location(s) at which the J-1 physician will provide medical services. This location can be different from the sponsoring site location if, for example, a satellite office is used.

Primary Care Fields The following four fields are identified as primary care: family practice, general internal medicine, general pediatrics and obstetrics/gynecology.

Processing Fees The Bureau of Health Planning and Resources Management within the Delaware Division of Public Health shall charge a non-refundable processing fee of \$200 to each sponsoring site submitting a Site Application at the time the application is submitted. A non-refundable processing fee of \$250 shall be charged to each pre-approved site to process the waiver request application for each J-1 physician that the site plans to employ. The check will be made payable to the State of Delaware.

Recruitment Contact Primary point of contact to be used by Delaware Health and Social Services Conrad State 30 Program Manager.

Service Area	Geographic area in closest proximity to the practice site, from which the majority of patients are derived.
Sponsoring Site	Medical practice through which the J-1 physician will provide medical services (i.e. the hiring organization).

The appendices for this regulation are found at the following website:
www.state.de.us/research/register/February2007/J-1Appendices.pdf

DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Section 311 (18 Del.C. § 311)
 18 DE Admin. Code 608

PUBLIC NOTICE

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of a proposed change to **Regulation 608** relating to **Automobile Insurance Coverage**. The docket number for this proposed amendment is 358.

The proposed change to the regulation provides that insurers of private and commercial insurers authorized to issue private automobile insurance in this State shall provide a telephone number and email address to the Department of Insurance by and through which any insured or other claimant for benefits could contact the insurer for claims or claim related inquiries. The proposed amendment can also be viewed at the Delaware Insurance Commissioner's website at: <http://www.state.de.us/inscom/departments/documents/ProposedRegs/ProposedRegs.shtml>.

The Department of Insurance does not plan to hold a public hearing on the proposed changes. Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed amendment. Any written submission in response to this notice and relevant to the proposed change must be received by the Department of Insurance no later than 4:30 p.m., Monday, March 5, 2007, and should be addressed to Deputy Attorney General Michael J. Rich, c/o Delaware Department of Insurance, 841 Silver Lake Boulevard, Dover, DE 19904, or sent by fax to 302.739.5566 or email to michael.rich@state.de.us.

608 Automobile Insurance Coverage [Formerly Regulation 45]

1.0 Purpose and Statutory Authority

1.1 The purpose of this regulation is to provide for timely notice of coverage termination for short term automobile insurance coverage and for contact information for claim related matters. This regulation is promulgated pursuant to 18 Del.C. §311. This regulation should not be construed to create any cause of action not otherwise existing at law.

2.0 Application

2.1 This regulation shall apply to all private passenger automobile insurance policies issued for a period of less than six months. The regulation will not apply to commercial policies. Sections 2 and 3 of this regulation shall not apply to commercial automobile insurance policies.

(Break in Continuity of Sections)

4.0 ~~Effective Date~~ Insurer's Obligation to Provide Contact Information

4.1 This regulation shall become effective February 1, 1985. Every insurer authorized to issue private automobile insurance in this State shall provide a telephone number and email address to the Department of

Insurance by and through which any insured or other claimant for benefits could contact the insurer for claims or claim related inquiries.

DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Sections 311 and 332 (18 **Del.C.** §§ 311, 332 and 6401 *et seq.*)
18 DE Admin. Code 1301

PUBLIC NOTICE

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of proposed amendments to Department of Insurance **Regulation 1301** relating to **Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims**. The docket number for this proposed regulation is 356.

The Department of Insurance proposes to amend Regulation 1301 by rescinding the current regulation and substituting in lieu thereof revised provisions for the review and arbitration of health insurance claims. As a result of the enactment of Senate Bill 295 on July 6, 2005 it became necessary to re-promulgate Regulation 1301 to provide for the review of claims from managed care organizations formerly under the regulatory authority of the Department of Health and Social Services. The **Delaware Code** authority for the change is 18 **Del.C.** §§311, 332 and 6401 *et seq.* The text can also be viewed at the Delaware Insurance Commissioner's website at www.delawareinsurance.gov and clicking on the link for "Proposed Regulations."

The Department of Insurance will hold a public hearing on the proposed changes on Monday, February 26, 2007 at 10:00 a.m. in the Consumer Services hearing room, 841 Silver Lake Blvd., Dover, DE 19904. Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed amendment. Any written submission in response to this notice and relevant to the proposed change must be received by the Department of Insurance no later than 4:30 p.m., March 6, 2007 by delivering said comments to Deputy Attorney General Michael J. Rich, c/o Delaware Department of Insurance, 841 Silver Lake Boulevard, Dover, DE 19904, or sent by fax to 302.739.5566 or emailed to michael.rich@state.de.us.

IT IS SO ORDERED this 8th day of January, 2007
Matthew Denn, Insurance Commissioner

~~1301 Arbitration of Health Insurance Claims and Internal Review Process of Medical Insurance Carriers~~

~~1-0 Purpose and Statutory Authority~~

~~The purpose of this Regulation is to implement 16 **Del.C.** §9119, 18 **Del.C.** §§332, 3348, 3559E, and 18 **Del.C.** Ch. 23 by establishing the procedures for the arbitration of certain claims for benefits available under health insurance policies or agreements, and/or the explicit provisions of the statutes under which this regulation is promulgated. This Regulation is promulgated pursuant to 18 **Del.C.** §§311, 2312, and 29 **Del.C.** Ch. 101 and 73 **Del. Laws** Ch. 96. This Regulation should not be construed to create any cause of action not otherwise existing at law.~~

~~2-0 Definitions~~

~~2.1 Except as otherwise noted, the following definitions shall apply:~~

~~"Commissioner" shall mean the Insurance Commissioner of Delaware.~~

~~"Department" shall mean the Delaware Insurance Department.~~

~~"Emergency care service" shall have the same meaning as contained in 18 **Del.C.** 3348(c) and 3559E and include:~~

~~• any covered service providing for the transportation of a patient to a hospital emergency facility for an emergency medical condition; including air and sea ambulances so long as medical necessity criteria are met; and~~

• facility and professional providers of emergency medical services in an approved emergency care facility.

~~"Emergency medical condition"~~ shall have the meaning assigned to it by 18 ~~Del.C.~~ §§3348(d) and 3559E(d).

~~"Health insurance policy"~~ shall have the meaning assigned to it by 18 ~~Del.C.~~ §332(a)8.

~~"Insured"~~ shall, in addition to its ordinary meaning, include the participants, subscribers or members of such health plans, health service corporations, medical care organizations or health maintenance organizations:

~~"Insurer" or "carrier,"~~ in addition to its ordinary meaning under 18 ~~Del.C.~~ §3343(a)(1), includes health plans, health service corporations, medical care organizations and health maintenance organizations subject to state insurance regulation.

~~"IRP"~~ shall mean an internal review process established by an insurer under 18 ~~Del.C.~~ §332.

~~"Network insurer"~~ is an insurer who has a written participation agreement with the provider to pay for emergency care services in Delaware on and after January 1, 2002.

~~"Network provider"~~ is a provider who has a written participation agreement with the insurer to provide emergency care services in Delaware as of the date those services were provided. All other providers of emergency care services shall be considered non network providers.

~~"Provider"~~ means an individual or entity, including without limitation, a licensed physician, a licensed nurse, a licensed physician assistant and a licensed nurse practitioner, a licensed diagnostic facility, a licensed clinical facility, and a licensed hospital, who or which provides an emergency care service in this State after January 1, 2002.

3.0 Insurer's Duty to Arbitrate

3.1 Except for claims exempt from arbitration by law or regulation, every insurer, carrier, provider, network provider and non-network provider giving or providing health and/or emergency medical services, and/or health insurance coverage or benefits in this State shall be subject to arbitration as follows:

3.1.1 For covered claims arising from the provision of emergency services under 18 ~~Del.C.~~ §§3348 and 3559E; and

3.1.2 For appeals from decisions of an IRP under 18 ~~Del.C.~~ §332 by the insured.

4.0 Exemption from Arbitration

4.1 Health claims or appeals which involve issues of medical necessity and/or the appropriateness of services, as defined in 16 ~~Del.C.~~ §9119, shall be exempt from arbitration by the Department. Any claims or appeals arising under 16 ~~Del.C.~~ §9119 and filed with the Department shall be deemed properly filed if actually received by the Department within in the allotted statutory time and such appeals shall, within 7 days from the date the Department determines that such appeals are exempt or excluded from arbitration, be forwarded by the Department through normal state channels to the Department of Health and Social Services, or its appropriate successor agency, for external under 16 ~~Del.C.~~ §9119 and such other laws and regulations as are applicable to said claims or appeals.

4.2 18 ~~Del.C.~~ §§3348 and 3559E shall not apply to health insurance policies exempt from state regulation under federal law or regulation. On or before July 1, 2002, and quarterly thereafter, each insurer shall provide a list of non-exempt plan numbers, as defined in 18 ~~Del.C.~~ §§3348 and 3559E to the Department. The Department shall maintain a public register of such non-exempt plan numbers. The placement of a non-exempt plan number on the register shall constitute a rebuttable presumption that such non-exempt plan number is subject to the provisions of this regulation. An insurer that clearly identifies whether a plan is either exempt or non-exempt on the face of an identification or membership card shall not be required to comply with the provisions of this subsection but only with respect to the plans for which such identification or membership cards display the group status.

4.3 The provisions of this regulation shall not apply to Medicaid or any other health insurance coverage program where the review of coverage determinations are otherwise regulated by the provisions of other state or federal laws or regulations.

5.0 Exclusion from Arbitration

5.1 The following claims shall not be subject to arbitration under this regulation:

- ~~5.1.1 Claims for which there is no jurisdiction under 18 Del.C. §332.~~
- ~~5.1.2 Claims that are already pending before any court or other administrative agency; or~~
- ~~5.1.3 Claims that have been exempted by the Commissioner under section 4.0 of this~~

regulation.

~~5.2 The Arbitration Secretary or Arbitrator is authorized to dismiss a matter upon receipt of information sufficient to establish that the claim is excluded under section 5.1 and after notice and an opportunity to respond is provided the claimant.~~

6.0 Minimum Requirements for an Internal Review Process (IRP)

~~In addition to the requirements set forth in 18 Del.C. §332, the following provisions shall govern the internal review process of all insurers subject to state jurisdiction offering health coverage in Delaware:~~

~~6.1 All written procedures and forms utilized by a insurer shall be readable and understandable by a person of average intelligence and education. All such documents shall meet the following criteria:-~~

- ~~6.1.1 The type size shall not be smaller than 11 point;~~
- ~~6.1.2 The type style selection shall be at the discretion of the insurer but shall be of a~~

~~type that is clear and legible;~~

- ~~6.1.3 Captions or headings shall be designed to stand out clearly;~~
- ~~6.1.4 White space separating subjects or sections should be distinct;~~
- ~~6.1.5 There must be included a table of contents sufficient to guide and assist the~~

~~insured;~~

- ~~6.1.6 Where appropriate definitions shall be included and shall be sufficient to clearly~~

~~apply to the usage intended.~~

- ~~6.1.7 The forms shall be written in everyday, conversational language to the extent~~

~~possible to preserve the legal meaning.-~~

- ~~6.1.8 Short familiar words shall be used and sentences shall be kept as short and~~

~~simple as possible.~~

~~6.2 All forms relating to grievances, appeals, or other procedures relating to the IRP shall be provided as examples along with the written IRP provided to the insured by the insurer.~~

~~6.3 The first notice of an IRP shall be given to all participants of an insurer within thirty (30) days of approval by the Commissioner. The annual notice thereafter shall either be upon the policy renewal date, open enrollment date, or a set date for all insureds or participants of the insurer, at the insurer's discretion. For every new policy issued after the approval of the IRP by the Commissioner, the insurer shall provide a copy of the IRP at the time, or prior to the time, the insurer sends identification cards, members handbooks or similar member materials to newly insured participants. When the insured's dependents reside in the same household as the insured, a single notice to the principal insured shall be sufficient under this section.~~

~~6.4 Under circumstances where an oral or written grievance may not contain sufficient information and the insurer requests additional information, such request shall not be burdensome or require such information as the insurer might reasonably be expected to obtain through its normal claims process.~~

7.0 Mediation Services

~~7.1 At the time the insurer provides a written notice of an unfavorable disposition of a claim or grievance to an insured, the insurer shall provide the insured with a written notice of mediation services offered by the Delaware Insurance Department. Such notice may be separate from or a part of the written notice of disposition of a claim or grievance. Any notice provided to an insured shall, at a minimum, contain the following information:~~

~~You have the right to appeal a claim denial for medical reasons to the Delaware Department of Health and Social Services or to appeal a claim denial for non medical reasons to the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to appeal this decision. You can contact the Delaware Insurance Department for information about an appeal or mediation by calling the Consumer Services Division at 800-282-8611 or 302-739-4251. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the appeal or mediation process. All appeals must be filed within 60 days from the date you receive this notice otherwise this decision will be final.~~

8.0 Payments for Emergencies Based on Date of Service

~~8.1 Under 18 Del.C. §§3348 and 3559E the Commissioner shall be responsible for setting rates and charges in the event of a dispute between an insurer and a provider. In an arbitration pursuant to said statutes, the Arbitrator shall consider the following guidelines as a basis for determining the rate or charge for a disputed service unless the evidence adduced under section 9.5 at arbitration requires a determination on a different basis.~~

~~8.2 Payments for existing emergency care services as of July 1, 2002. Effective on July 1, 2002, under circumstances where the contract between the provider and insurer was terminated after January 1, 2002, insurers will pay such provider the highest contract rate for the services provided during the term of the contract for services identified in 18 Del.C. §§3348 or 3559E, adjusted annually to reflect changes in payments by that insurer to its network providers and subject to such rate adjustments as may be published in bulletins by the Commissioner from time to time. Effective on July 1, 2002, insurers will pay non-network providers who were not network providers on or after January 1, 2002 the higher of either (1) the highest payment rate paid by the insurer to the non-network provider for performance of the same service; or (2) the highest undisputed amount regularly paid by any network insurer to the non-network provider for performance of the same service. All payments pursuant to this section are subject to reduction based on the insured's obligations for co-payments or deductibles.~~

~~8.3 Payments for new emergency care services after July 1, 2002. Each insurer shall pay non-network providers for each emergency medical care service after July 1, 2002, an amount equal to the lesser of the non-network provider billed fee for such new service or the highest negotiated rate between the insurer and any network provider for the service based on the appropriate CPT code until such time as the provider becomes a network provider pursuant to a written participation agreement. Thereafter payments will be based on the new negotiated rates.~~

~~8.3 Payments for new emergency care services that receive CPT codes on or after July 1, 2002. Effective on or after July 1, 2002, for services that do not have a CPT code or other identifiable code number, each insurer shall pay non-network providers the lesser of: the provider billed fee, or the highest negotiated network rate received by the provider from any insurer for the performance of the same service. When and if the provider becomes a network provider with insurer, payments will be based on the negotiated rate.~~

~~8.4 Subsequent to January 1, 2002, changes in the membership of a provider group will not affect the remaining group member(s) insofar as the application of this section to payments for emergency services. In the absence of a contract provision to the contrary, a physician's existing network status and payment rights shall not be transferable to that physician's new group or practice.~~

9.0 General Procedures Applicable to Arbitrations

~~9.1 In arbitration proceedings and practice, the person(s), firm(s) or entity(ies) who initiates the proceeding by filing a petition for arbitration of a disputed claim or issue with the Commissioner shall be known as the "claimant(s)," and the person(s), firm(s) or entity(ies) against whom such claim or claims is asserted shall be known as "respondent(s)."~~

~~9.2 A petition for arbitration shall be in writing and filed in the office of the Commissioner on or before the sixtieth day following the claimant's receipt of the written adverse determination or denial.~~

~~9.3 The parties must provide a brief statement certifying the service of all filed papers with the manner, date and address of service. A certification of service using Form C in the appendix to this Regulation shall be satisfactory if mailed to the opposing party as required by this Regulation.~~

9.4 Notice and Manner of Service.

~~9.4.1 Notice and manner of service, except service of the original petition, is sufficient and complete if properly addressed, upon mailing the same with prepaid first class U.S. Postage.~~

~~9.4.2 Service of an original petition shall be by Certified U.S. Postage and Return receipt requested or hand delivery to the respondent and is complete upon receipt by addressee or an employee in respondent's place of business.~~

~~9.5 In any arbitration pursuant to 18 Del.C. §§3348 or 3559E, the Arbitrator shall, at a minimum, receive evidence relating to the following items:~~

~~9.5.1 The highest amount of money paid by the insurer to a provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;~~

~~9.5.2 The lowest amount of money paid by the insurer to a provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;~~

~~9.5.3 The highest amount of money received by a provider from the insurer for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;~~

~~9.5.4 The lowest amount of money received by a provider from the insurer for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;~~

~~9.5.5 The number of times during the preceding twelve months that the insurer experienced a dispute or disagreement with respect to the payment for the particular service in a comparable medical facility where the service was provided and the outcome of such disputes or disagreements.~~

~~9.5.6 Such information as may be provided to the Arbitrator pursuant to an arbitration shall presumptively be considered trade secret or confidential financial information under the Delaware Freedom of Information Act and shall not be disclosed to or available at any time to any person, firm or entity not involved in the arbitration. Likewise, any personal health information introduced into evidence as part of the arbitration shall not be disclosed to or available at any time to any person, firm or entity not involved in the arbitration.~~

~~9.6 In arbitrations commenced under 18 Del.C. §332, the insurer shall pay the costs and fees of arbitration which exceed the non-refundable filing fee of \$75.00 required to commence arbitration.~~

~~9.7 In arbitrations commenced under 18 Del.C. §§3348 or 3559E, the non-prevailing party(ies) shall pay the costs and fees of arbitration which exceed the non-refundable filing fee of \$75.00 required to commence arbitration.~~

10.0 Commencement of Arbitration

~~10.1 An arbitration will commence upon the filing of an original and three copies of a petition, in acceptable form with the Commissioner's Arbitration Secretary with the supporting documents or other evidence attached thereto and payment of the non-refundable filing fee of \$75.00. The claimant shall, at the same time, send a copy of the petition and supporting documents to the respondent as required in section 9.0. The Arbitration Secretary may refuse to accept any petition which fails to meet the jurisdictional requirements for arbitration. The failure to file a petition which meets the jurisdictional requirements for arbitration shall not toll the time allowed to file for arbitration.~~

~~10.2 Within 20 days of receipt of the petition, the respondent shall file an original and three copies of a response, in acceptable form, with the Arbitration Secretary with supporting documents or other evidence attached. The respondent shall, at the same time, send a copy of the response and supporting documents to the claimant as required in section 9.0. The Arbitration Secretary may return any non-conforming response. If the Arbitration Secretary or Arbitrator determines at any time that the petition fails to meet the jurisdictional requirements of the statute or this regulation or is meritless on its face, the petition may be summarily dismissed by the Arbitration Secretary or Arbitrator and notice of such dismissal shall be provided to the parties. The non-prevailing party may seek to have the petition re-opened under the provisions of 10.3 of this section.~~

~~10.3 If the respondent fails to file a response in a timely fashion, the Arbitration Secretary after verifying proper service and notice to the parties may assign the matter to the next scheduled Arbitrator for summary disposition. The Arbitrator may determine the matter in the nature of a default judgment after establishing that the petition is properly supported and was properly served on respondent. The Arbitration Secretary or Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than 5 business days after notice of the default judgment.~~

~~10.4 Upon the filing of a proper response, the Arbitration Secretary shall assign and schedule the matter for a hearing before an Arbitrator.~~

11.0 Arbitration

~~The Commissioner shall appoint a single arbitrator of suitable background and experience to hear any case presented for arbitration under this regulation. No arbitrator may be selected where the arbitrator's employer or client is a party. The Arbitrator shall act as the Commissioner's designee and shall issue a written opinion as required by 29 Del.C. §10126.~~

12.0 Arbitration Hearings

~~12.1 The arbitration hearing shall be scheduled and notice of the hearing shall be given the parties at least 10 business days prior to the hearing. Neither party is required to appear and may rely on the filed papers.~~

~~12.2 The purpose of Arbitration is an attempt to effect a prompt and inexpensive resolution of claims after reasonable attempts by the parties to resolve the matter. In keeping with that goal arbitration hearings shall~~

PROPOSED REGULATIONS

~~be conducted in accordance with the provisions of the 29 Del.C. Ch. 101. The arbitration hearing is not a substitute for a civil trial. Accordingly, The Delaware Rules of Evidence will be used for general guidance but will not be strictly applied. Hearings are to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence in support of the pleading and to answer questions by the Arbitrator. If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross examination or other response by the opposing party. Because the testimony may involve evidence relating to personal health information that is confidential and protected by other state or federal laws from public disclosure, the arbitration hearings shall be closed unless otherwise agreed by the parties.~~

~~12.3 The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter.~~

~~12.4 The Arbitrator is to consider the matter based on the submissions of the parties and information otherwise obtained by the Arbitrator in accordance with this regulation. The Arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least 5 business days notice, except claims of a continuing nature which are set out in the filed papers.~~

~~12.5 The Arbitrator shall render his/her decision and mail a copy of the decision to the parties within 45 days of the filing of the petition. Upon mailing said decision, the time limits imposed by 29 Del.C. §10126 shall apply for the parties' review and execution of the order by the Commissioner.~~

13.0 Appeals

~~13.1 Appeals from the decision of the Commissioner shall be taken to the Superior Court of the State of Delaware by filing a copy of the Notice of Appeal, as filed in the Superior Court, with the Arbitration Secretary.~~

~~13.2 The Rules of Civil Procedure of the Superior Court shall govern all appeal procedures.~~

~~13.3 Any appeal which, as a matter of law, has to be filed in a court other than the Superior Court, shall be subject to the rules of such court and the appellant shall file a copy of the Notice of Appeal to such court with the Arbitration Secretary.~~

14.0 Confidentiality of Health Information

~~Nothing in this Regulation shall supercede any federal or state law or regulation governing the privacy of health information.~~

15.0 Effective Date

~~This regulation shall become effective on the 11 day of March, 2002.~~

Adopted And Signed By The Commissioner, February 15, 2002

Appendix
Regulation 1301 (Formerly Regulation 11) Form A
PETITION For Health Insurance Arbitration

Your Name _____

Your Address _____

Your Telephone Number _____

Were You: Patient Spouse Parent or Guardian Power of Attorney Other _____

Name Of The Insurance Co. Against Which You Are Making A Claim _____

Case Number _____

Address _____

Telephone Number _____

PROPOSED REGULATIONS

1239

Name Of The Policyholder If Other Than You _____
Address, If Different From Above _____
Date Of Determination Of Independent Review Process _____
Amount Of Your Claim _____

Dates Of Service (From) _____ (To) _____
Briefly Describe The Basis For Your Claim _____

Prior To The Hearing, It Is Necessary That You Submit The Appropriate Documents To Support Your Petition To The Delaware Insurance Department And To The Opposing Party.

Parties May Present Witnesses In Their Behalf At The Hearing Provided That Due Notice Is Given. Please List The Name, Address And Telephone Number Of All Witnesses You Expect To Appear On Your Behalf On A Separate Sheet And Attach It To This Form.

If A Settlement Has Been Offered To You, How Much Was It: _____

Who Will Represent You At The Hearing, If Applicable

Name _____
Address _____
Telephone _____

Under Delaware Law, Any Person Who Knowingly, And With Intent To Injure, Defraud, Or Deceive Any Insurer Who Files A Statement Or Claim Containing Any False, Incomplete, Or Misleading Information Is Guilty Of A Felony

Your Signature _____

date _____

Return The Original And Three Copies To: Delaware Insurance Department, 841 Silver Lake Boulevard, Dover, Delaware 19904

Regulation 1301 (Formerly Regulation 11) Form B
Response To Petition For Health Insurance Arbitration

Case Number _____

Claimant's Name _____

Policyholder's Name (If Different From Claimant) _____

Address (If Different From Claimant) _____

Respondent's Name _____

Address _____

Telephone _____

If The Petition Relates To The Services Of An Individual Physician, Include The Following Information:

Physician's Name And Practice Group _____

Address _____

Telephone _____

Policy Number _____

PROPOSED REGULATIONS

Claim Number Assigned By Respondent _____

Date Of Determination Of Independent Review Process _____

Amount Of Claim Admitted By Respondent _____

Dates Of Service _____

(From) _____ (To) Briefly Describe The Basis For Your Response/objection To The Petition _____

Prior To The Hearing, It Is Necessary That You Submit The Appropriate Documents To Support Your Petition To The Delaware Insurance Department And To The Opposing Party.

Parties May Present Witnesses In Their Behalf At The Hearing Provided That Due Notice Is Given. Please List The Name, Address And Telephone Number Of All Witnesses You Expect To Appear On Your Behalf On A Separate Sheet And Attach It To This Form.

If A Settlement Has Been Offered To You, How Much Was It: _____

Who Will Represent You At The Hearing

Name _____

Address _____

Telephone _____

Under Delaware Law, Any Person Who Knowingly, And With Intent To Injure, Defraud, Or Deceive Any Insurer Who Files A Statement Or Claim Containing Any False, Incomplete, Or Misleading Information Is Guilty Of A Felony

Your Signature _____ date _____

Return The Original And Three Copies To: Delaware Insurance Department, 841 Silver Lake Boulevard, Dover, Delaware 19904

Regulation 11-form C

Proof Of Service Of Papers Required For Arbitration

I Certify That On The _____ day Of _____, 20____, In Addition To The Filing Provided To The Insurance Commissioner, I Sent A Copy Of The _____ Complaint For Arbitration With Required Attachments _____ Response To The Complaint For Arbitration With Required Attachments _____

Other

(Please Describe) _____

To The Following Person(S) By Certified Mail, Return Receipt Requested:

Name _____

Address _____

Name _____

Address _____

The Following Is Required By The Person Making This Certification

Name Of Party _____

Signature Of Party _____

Address Of Party _____

Note: Save All Proofs Of Mailing And Return Receipt(S) For Verification By The Arbitrator.

1301 Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims

1.0 Purpose and Statutory Authority

1.1 The purpose of this Regulation is to implement 18 Del.C. §§332, 6416 and 6417 which require health insurance carriers to establish a procedure for internal review of a carrier's adverse coverage determination and which require the Delaware Insurance Department to establish and administer procedures for arbitration and independent utilization review upon completion of the carrier's internal review process. This Regulation also implements 18 Del.C. §§3349 and 3565, which require the Delaware Insurance Department to establish and administer procedures for arbitration of disputes between health insurance carriers and non-network providers of emergency care services. This Regulation is promulgated pursuant to 18 Del.C. §§311, 332, 3349, 3565 and 6408 and 29 Del.C., Ch. 101. This Regulation should not be construed to create any cause of action not otherwise existing at law.

2.0 Definitions

2.1 The following words and terms, when used in this regulation, should have the following meaning unless the context clearly indicates otherwise:

"Adverse determination" means a decision by a carrier to deny (in whole or in part), reduce, limit or terminate health insurance benefits.

"Appeal" means a request for external review of a carrier's final coverage decision through the Independent Health Care Appeals Program.

"Appropriateness of services" means an appeal classification for adverse determinations that are made based on identification of treatment as cosmetic, investigational, experimental or not an appropriate or preferred treatment method or setting for the condition for which treatment is sought.

"Authorized representative" means an individual who a covered person willingly acknowledges to represent his interests during the internal review process, arbitration and/or an appeal through the Independent Health Care Appeals Program, including but not limited to a provider to whom a covered person has assigned the right to collect sums due from a carrier for health care services rendered by the provider to the covered person. A carrier may require the covered person to submit written verification of his consent to be represented. If a covered person has been determined by a physician to be incapable of assigning the right of representation, the covered person may be represented by a family member or a legal representative.

"Carrier" means any entity that provides health insurance in this State. Carrier includes an insurance company, health service corporation, managed care organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. Carrier also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health insurance.

"Covered person" means an individual and/or family who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with a carrier, pursuant to which the carrier provides health insurance for such person or persons.

"Department" means the Delaware Insurance Department.

"Emergency care provider" means a provider of emergency care services.

"Emergency care services" means those services identified in 18 Del.C. §§3349(c) and 3565(c) including:

A. Any covered service providing for the transportation of a patient to a hospital emergency facility for an emergency medical condition including air and sea ambulances so long as medical necessity criteria are met; and

B. Facility and professional providers of emergency medical services in an approved emergency care facility.

"Emergency medical condition" shall have the meaning assigned to it by 18 Del.C. §§3349(d) and 3565(d).

"Final coverage decision" means the decision by a carrier at the conclusion of its internal review process upholding, modifying or reversing its adverse determination.

"Grievance" means a request by a covered person or his authorized representative that a carrier review an adverse determination by means of the carrier's internal review process.

"Health care services" means any services or supplies included in the furnishing to any individual of medical or dental care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as

the furnishing to any individual of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury, disability or disease.

“Health insurance” means a plan or policy issued by a carrier for the payment for, provision of, or reimbursement for health care services.

“Independent Health Care Appeals Program (“IHCAP”)” means a program administered by the Department that provides for an external review by an Independent Utilization Review Organization of a carrier’s final coverage decision based on medical necessity or appropriateness of services.

“Independent Utilization Review Organization (“IURO”)” means an entity that conducts independent external reviews of a carrier’s final coverage decisions resulting in a denial, termination, or other limitation of covered health care services based on medical necessity or appropriateness of services.

“Internal review process (“IRP”)” means a procedure established by a carrier for internal review of an adverse determination.

“Medical necessity” means providing of health care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

- A. In accordance with generally accepted standards of medical practice;
- B. Consistent with the symptoms or treatment of the condition; and
- C. Not solely for anyone’s convenience.

“Network carrier” is a carrier that has a written participation agreement with an emergency care provider to pay for emergency care services in Delaware.

“Network emergency care provider” is an emergency care provider who has a written participation agreement with the carrier to provide emergency care services or governing payment of emergency care services in Delaware as of the date those services were provided. All other emergency care providers shall be considered non-network emergency care providers.

“Provider” means an individual or entity, including without limitation, a licensed physician, a licensed nurse, a licensed physician assistant and a licensed nurse practitioner, a licensed diagnostic facility, a licensed clinical facility, and a licensed hospital, who or which provides health care services in this State.

3.0 Minimum Requirements for an Internal Review Process (IRP)

In addition to the requirements set forth in 18 Del.C. §332, the following provisions shall govern the internal review process of all carriers offering health insurance in Delaware:

3.1 All written procedures and forms utilized by a carrier shall be readable and understandable by a person of average intelligence and education. All such documents shall meet the following criteria:

3.1.1 The type size shall not be smaller than 11 point;

3.1.2 The type style selection shall be at the discretion of the carrier but shall be of a type that is clear and legible;

3.1.3 Captions or headings shall be designed to stand out clearly;

3.1.4 White space separating subjects or sections should be distinct;

3.1.5 There must be included a table of contents sufficient to guide and assist the covered person or his authorized representative;

3.1.6 Where appropriate, definitions shall be included, shall be sufficient to clearly apply to the usage intended, and shall not conflict with the definitions contained in this regulation.

3.1.7 The forms shall be written in everyday, conversational language to the extent possible to preserve the legal meaning.

3.1.8 Short familiar words shall be used and sentences shall be kept as short and simple as possible.

3.2 The carrier shall provide all forms relating to grievances, appeals, arbitration or other procedures relating to IRP as examples along with the written notice of IRP provided to the covered person.

3.3 Written notice.

3.3.1 For any IRP not previously approved by the Department, the carrier shall provide written notice of the IRP to all covered persons within 30 days of approval by the Department.

3.3.2 The carrier shall provide the annual notice required by 18 Del.C. §332(c)(1) to covered persons either upon the policy renewal date, open enrollment date, or a set date for all covered persons, in the carrier’s discretion.

3.3.3 For every new policy issued after the Department's approval of the IRP, the carrier shall provide covered persons with a copy of the IRP at the time, or prior to the time, the carrier sends identification cards, member handbooks or similar member materials to newly covered persons.

3.3.4 When a covered person's dependents reside in the same household as the covered person, a single notice to the principal covered person shall be sufficient under this section.

3.4 Under circumstances where an oral or written grievance may not contain sufficient information and the carrier requests additional information, such request shall not be burdensome or require such information as the carrier might reasonably be expected to obtain through its normal claims process.

4.0 Mediation Services

At the time a carrier provides to a covered person written notice of a carrier's final coverage decision, if the decision does not authorize payment of the claim in its entirety, the carrier shall provide the covered person with a written notice of mediation services offered by the Department. Such notice may be separate from or a part of the written notice of the carrier's decision. Any notice provided to a covered person shall, at a minimum, contain the following language:

"You have the right to seek review of a claim denial through the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to review of this decision. You can contact the Delaware Insurance Department for information about claim denial review or mediation by calling the Consumer Services Division at 800-282-8611 or 302-739-4251. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the review or mediation process. All requests for review through procedures established by the Delaware Insurance Department must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final."

5.0 Options for External Review of a Carrier's Final Coverage Decision

5.1 A covered person or his authorized representative may request review of a carrier's final coverage decision through the Department by filing either a Petition for Arbitration or filing an appeal through the Independent Health Care Appeals Program, depending on the basis for the carrier's final coverage decision as set forth herein.

5.2 Arbitration (sections 6.0 and 7.0 of this regulation). Except for claims exempt from arbitration by law or regulation, every carrier, provider, network emergency care provider and non-network emergency care provider as defined in this regulation shall submit to arbitration the following:

5.2.1 covered claims arising from the provision of emergency care services under 18 Del.C. §§3349 and 3565; and

5.2.2 final coverage decisions denying claims based on grounds other than medical necessity or appropriateness of services.

5.3 Independent Health Care Appeals Program (sections 8.0 through 11.0 of this regulation). A carrier shall submit all requests for review of final coverage decisions denying claims based, in whole or in part, on medical necessity or appropriateness of services ("appeals") to the Independent Health Care Appeals Program ("IHCAP").

5.3.1 For cases in which a carrier's final coverage decision should be reviewed through arbitration and through IHCAP, or where there is an ambiguity as to whether review should be through arbitration or through IHCAP, review shall be conducted through IHCAP.

5.4 Exemption from Arbitration. 18 Del.C. §§3349(b) and 3565(b) shall not apply to health insurance policies exempt from state regulation under federal law or regulation. On a quarterly basis, each carrier shall provide a list of non-exempt plan numbers to the Department. The Department shall maintain a public register of such non-exempt plan numbers. The placement of a non-exempt plan number on the register shall constitute a rebuttable presumption that such non-exempt plan number is subject to the provisions of this regulation. A carrier that clearly identifies whether a plan is either exempt or non-exempt on the face of an identification or membership card shall not be required to comply with the provisions of this sub-section but only with respect to the plans for which such identification or membership cards display the group status.

5.5 The provisions of this regulation shall not apply to Medicaid or any other health insurance program

where the review of coverage determinations is otherwise regulated by the provisions of other state or federal laws or regulations.

6.0 Arbitration Procedure

6.1 Petition for Arbitration

6.1.1 A covered person or his authorized representative may request review of a carrier's final coverage decision through arbitration by delivering a Petition for Arbitration to the Department so that it is received by the Department no later than 60 days after the covered person's receipt of written notice of the carrier's final coverage decision.

6.1.2 A covered person or his authorized representative must deliver to the Department an original and three copies of the Petition for Arbitration.

6.1.3 At the time of delivering the Petition for Arbitration to the Department, a covered person or his authorized representative must also:

6.1.3.1 send a copy of the Petition to the carrier by certified mail, return receipt requested;

6.1.3.2 deliver to the Department a Proof of Service confirming that a copy of the Petition has been sent to the carrier by certified mail, return receipt requested; and

6.1.3.3 deliver to the Department a non-refundable \$75.00 filing fee.

6.1.4 The Department may refuse to accept any Petition that is not timely filed or does not otherwise meet the criteria for arbitration. If the subject of the Petition is appropriate for review through IHCAP, the Department shall advise the covered person or his authorized representative of the procedure to obtain IHCAP review. If the subject of the Petition is appropriate for IHCAP review, the Petition for Arbitration will be treated as an IHCAP appeal for purposes of determining whether the IHCAP appeal is timely filed in accordance with section 8.1 of this regulation.

6.2 Response to Petition for Arbitration

6.2.1 Within 20 days of receipt of the Petition, the carrier must deliver to the Department an original and three copies of a Response with supporting documents or other evidence attached.

6.2.2 At the time of delivering the Response to the Department, the carrier must also:

6.2.2.1 send a copy of the Response and supporting documentation to the covered person or his authorized representative by first class U.S. mail, postage prepaid; and

6.2.2.2 deliver to the Department a Proof of Service confirming that a copy of the Response was mailed to the covered person or his authorized representative.

6.2.3 The Department may return any non-conforming Response to the carrier.

6.2.4 If the carrier fails to deliver a Response to the Department in a timely fashion, the Department, after verifying proper service, and with written notice to the parties, may assign the matter to the next scheduled Arbitrator for summary disposition.

6.2.4.1 The Arbitrator may determine the matter in the nature of a default judgment after establishing that the Petition is properly supported and was properly served on the carrier.

6.2.4.2 The Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than seven days after notice of the default judgment.

6.3 Summary Dismissal of Petition by the Department

6.3.1 If the Department determines that the subject of the Petition is not appropriate for arbitration or IHCAP or is meritless on its face, the Department may summarily dismiss the Petition and provide notice of such dismissal to the parties.

6.4 Appointment of Arbitrator

6.4.1 Upon receipt of a proper Response, the Department shall assign an Arbitrator who shall schedule the matter for a hearing so that the Arbitrator can render a written decision within 45 days of the delivery to the Department of the Petition for Arbitration.

6.4.2 The Arbitrator shall be of suitable background and experience to decide the matter in dispute and shall not be affiliated with any of the parties or with the provider whose service is at issue in the dispute.

6.5 Arbitration Hearing

6.5.1 The Arbitrator shall give notice of the arbitration hearing date to the parties at least 10 days prior to the hearing. The parties are not required to appear and may rely on the papers delivered to the Department.

6.5.2 The arbitration hearing is to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence and to answer questions by the Arbitrator.

6.5.3 If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross-examination or other response by the opposing party.

6.5.4 The Delaware Uniform Rules of Evidence will be used for general guidance but will not be strictly applied.

6.5.5 Because the testimony may involve evidence relating to personal health information that is confidential and protected by state or federal laws from public disclosure, the arbitration hearing shall be closed unless otherwise agreed by the parties.

6.5.6 The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter.

6.5.7 The Arbitrator is to consider the matter based on the submissions of the parties and information otherwise obtained by the Arbitrator in accordance with this regulation. The Arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least five days notice, except claims of a continuing nature that are set out in the filed papers.

6.6 Arbitrator's Written Decision.

6.6.1 The Arbitrator shall render his decision and mail a copy of the decision to the parties within 45 days of the filing of the Petition.

6.6.2 The Arbitrator's decision is binding upon the carrier except as provided in 18 Del.C. §332(g).

6.7 Arbitration Costs.

6.7.1 In arbitrations commenced under 18 Del.C. §332, the carrier shall pay the costs and fees of arbitration which exceed the non-refundable filing fee of \$75.00 required to commence arbitration.

6.7.2 In arbitrations commenced under 18 Del.C. §§3349 or 3565, the non-prevailing party(ies) shall pay the costs and fees of arbitration which exceed the non-refundable filing fee of \$75.00 required to commence arbitration.

7.0 Special Provisions Applicable to Arbitration Pursuant to 18 Del.C. §§3349 and 3565

7.1 In any arbitration pursuant to 18 Del.C. §§3349 or 3565, the Arbitrator shall, at a minimum, receive evidence relating to the following items:

7.1.1 The highest amount of money paid by the carrier to any emergency care provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

7.1.2 The lowest amount of money paid by the carrier to any emergency care provider for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

7.1.3 The highest amount of money received by the non-network emergency care provider from any carrier for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

7.1.4 The lowest amount of money received by the non-network emergency care provider from any carrier for the particular service in a comparable medical facility where the service was provided during the preceding twelve months;

7.1.5 The number of times during the preceding twelve months that the carrier experienced a dispute or disagreement with respect to the payment for the particular service in a comparable medical facility where the service was provided, and the outcome of such disputes or disagreements.

7.2 The information specified in section 7.1 of this regulation and provided to the Arbitrator shall presumptively be considered trade secret or confidential financial information under the Delaware Freedom of Information Act and shall not be disclosed to or available at any time to any person, firm or entity not involved in the arbitration.

7.3 The Arbitrator shall consider the following guidelines as a basis for determining the rate or charge for a disputed service unless the evidence adduced at arbitration requires a determination on a different basis:

7.3.1 *Payments for emergency care services with CPT codes.* A carrier shall pay non-network

emergency care providers an amount equal to the lesser of the non-network emergency care provider billed fee for such service or the highest negotiated rate between the carrier and any network provider for the service based on the appropriate CPT code until such time as the non-network provider becomes a network provider pursuant to a written participation agreement. Thereafter payments will be based on the new negotiated rates.

7.3.2 *Payments for emergency care services without CPT codes.* For emergency care services that do not have a CPT code or other identifiable code number, a carrier shall pay non-network emergency care providers the lesser of the non-network emergency care provider billed fee, or the highest negotiated network rate received by the non-network provider from any carrier for the performance of the same service. When and if the non-network provider becomes a network provider, payments will be based on the negotiated rate.

7.3.3 *Changes in the membership of a provider group will not affect the remaining group member(s) insofar as the application of this section to payments for emergency care services. In the absence of a contract provision to the contrary, a physician's existing network status and payment rights shall not be transferable to that physician's new group or practice.*

8.0 IHCAP Procedure

8.1 A covered person or his authorized representative may request review of a final coverage decision based on medical necessity or appropriateness of services by filing an appeal with the carrier within 60 days of receipt of the final coverage decision.

8.2 Upon receipt of an appeal, the carrier shall transmit the appeal electronically or by facsimile to the Department as soon as possible, but within no more than three business days, and shall send a hard copy of the request to the Department by mail.

8.3 Within five calendar days of receipt of an appeal, the Department shall assign an approved, impartial Independent Utilization Review Organization to review the final coverage decision and shall notify the carrier.

8.4 The assigned IURO shall, within five calendar days of assignment, notify the covered person or his authorized representative in writing by certified or registered mail that the appeal has been accepted for external review.

8.4.1 The notice shall include a provision stating that the covered person or his authorized representative may submit additional written information and supporting documentation that the IURO shall consider when conducting the external review.

8.4.2 The covered person or his authorized representative shall submit such written documentation to the IURO within seven calendar days following the date of receipt of the notice.

8.4.3 Upon receipt of any information submitted by the covered person or his authorized representative, the assigned IURO shall as soon as possible, but within no more than two business days, forward the information to the carrier.

8.4.4 The IURO must accept additional documentation submitted by the carrier in response to additional written information and supporting documentation from the covered person or his authorized representative.

8.5 Within seven calendar days after the receipt of the notification required in section 8.3, the carrier shall provide to the assigned IURO the documents and any information considered in making the final coverage decision.

8.5.1 If the carrier fails to submit documentation and information or fails to participate within the time specified, the assigned IURO may terminate the external review and make a decision, with the approval of the Department, to reverse the final coverage decision.

8.6 The external review may be terminated if the carrier decides to reverse its final coverage decision and provide coverage or payment for the health care service that is the subject of the appeal.

8.6.1 Immediately upon making the decision to reverse its final coverage decision, the carrier shall notify the covered person or his authorized representative, the assigned IURO, and the Department in writing of its decision. The assigned IURO shall terminate the external review upon receipt of the written notice from the carrier.

8.7 Within 45 days after the IURO's receipt of an appeal, the assigned IURO shall provide written notice of its decision to uphold or reverse the final coverage decision to the covered person or his authorized representative, the carrier and the Department, which notice shall include the following information:

8.7.1 the qualifications of the members of the review panel;

- 8.7.2 a general description of the reason for the request for external review;
- 8.7.3 the date the IURO received the assignment from the Department to conduct the external review;
- 8.7.4 the date(s) the external review was conducted;
- 8.7.5 the date of its decision;
- 8.7.6 the principal reason(s) for its decision; and
- 8.7.7 references to the evidence or documentation, including practice guidelines and clinical review criteria, considered in reaching its decision.
- 8.8 The decision of the IURO is binding upon the carrier except as provided in 18 **Del.C.** §6416(b).

9.0 Expedited IHCAP Procedure

- 9.1 A covered person or his authorized representative may request an expedited appeal at the time the carrier issues its final coverage decision if the covered person suffers from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition.
- 9.2 At the time the carrier receives request for an expedited appeal, the carrier shall immediately transmit the appeal electronically or by facsimile to the Department and shall send a hard copy to the Department by mail.
- 9.3 If the Department determines that the review meets the criteria for expedited review, the Department shall assign an approved, impartial IURO to conduct the external review and shall notify the carrier.
- 9.4 At the time the carrier receives the notification of the assigned IURO, the carrier shall provide or transmit all necessary documents and information considered in making its final coverage decision to the assigned IURO electronically, by telephone, by facsimile or any other available expeditious method.
- 9.5 As expeditiously as the covered person's medical condition permits or circumstances require, but in no event more than 72 hours after the IURO's receipt of the expedited appeal, the IURO shall make a decision to uphold or reverse the final coverage decision and immediately notify the covered person or his authorized representative, the carrier, and the Department of the decision.
- 9.6 Within two calendar days of the immediate notification, the assigned IURO shall provide written confirmation of its decision to the covered person or his authorized representative, the carrier, and the Department.
- 9.7 The decision of the IURO is binding upon the carrier except as provided in 18 **Del.C.** §6416(b).

10.0 Refusal or Dismissal of IHCAP Appeal

- 10.1 The Department may refuse to accept any appeal that is not timely filed or does not otherwise meet the criteria for IHCAP review. If the subject of the appeal is appropriate for arbitration, the Department shall advise the covered person or his authorized representative of the arbitration procedure. If the subject of the appeal is appropriate for arbitration, the appeal shall be treated as a Petition for Arbitration for purposes of determining whether the Petition is timely filed in accordance with section 6.1.1 of this regulation.
- 10.2 Carrier's motion to dismiss an IHCAP appeal.
- 10.2.1 A carrier may move to dismiss an IHCAP appeal if the carrier believes:
- 10.2.1.1 the appeal concerns a benefit that is the subject of an express written exclusion from the covered person's health insurance;
- 10.2.1.2 the appeal is appropriate for arbitration; or
- 10.2.1.3 the appeal should be dismissed because it is inappropriate for IHCAP review as explained in a sworn statement by an officer of the carrier.
- 10.2.2 The carrier's motion to dismiss must be made in writing at the time the carrier transmits the appeal to the Department and must include any necessary supporting documentation.
- 10.2.3 The Department shall review the appeal and motion for dismissal and may, in its discretion:
- 10.2.3.1 dismiss the appeal and notify the covered person or his authorized representative in writing that the appeal is inappropriate for the IHCAP; or
- 10.2.3.2 appoint an IURO to conduct a full external review.

11.0 IHCAP Costs

- 11.1 All costs for IHCAP review by an IURO, whether the review is preliminary, or partially or fully completed, shall be borne by the carrier.
- 11.2 The carrier shall reimburse the Department for the cost of the IHCAP review within 90 calendar

days of receipt of the decision by the IURO or within 90 days of termination of review by the IURO by other means.

12.0 Approval of Independent Utilization Review Organizations

12.1 The Department shall approve IUROs eligible to be assigned to conduct IHCAP reviews as provided in 18 Del.C. §6417(a).

12.2 An IURO seeking approval to conduct IHCAP reviews shall submit an application to the Department that includes the information required by 18 Del.C. §§6417(c)(1), 6417(c)(2), 6417(c)(4) and 6417(c)(4)(d).

12.3 The Department shall maintain a current list of approved IUROs.

13.0 Carrier Recordkeeping and Reporting Requirements

13.1 A carrier shall maintain written or electronic records documenting all grievances, Petitions for Arbitration and appeals for IHCAP review including, at a minimum, the following information:

13.1.1 For each grievance:

13.1.1.1 the date received;

13.1.1.2 name and plan identification number of the covered person on whose behalf the grievance was filed;

13.1.1.3 a general description of the reason for the grievance; and

13.1.1.4 the date and description of the final coverage decision.

13.1.2 For each Petition for Arbitration:

13.1.2.1 the date the Petition was filed;

13.1.2.2 name and plan identification number of the covered person on whose behalf the Petition was filed;

13.1.2.3 a general description of the reason for the Petition; and

13.1.2.4 date and description of the Arbitrator's decision or other disposition of the

Petition.

13.1.3 For each appeal for IHCAP review:

13.1.3.1 the date received;

13.1.3.2 name and plan identification number of the covered person on whose behalf the appeal was filed;

13.1.3.3 a general description of the reason for the appeal; and

13.1.3.4 date and description of the IURO's decision or other disposition of the

appeal.

13.2 A carrier shall file with its annual report to the Department the following information:

13.2.1 The total number grievances filed.

13.2.2 The total number of Petitions for Arbitration filed, with a breakdown showing:

13.2.2.1 the total number of final coverage decisions upheld through arbitration;

and

13.2.2.2 the total number of final coverage decisions reversed through arbitration.

13.2.3 The total number of IHCAP appeals filed, with a breakdown showing:

13.2.3.1 the total number of final coverage decisions upheld through IHCAP; and

13.2.3.2 the total number of final coverage decisions reversed through IHCAP.

13.3 A carrier shall make available to the Department upon request any of the information specified in the foregoing sections 13.1 and 13.2, and other information regarding its internal review process including but not limited to the written IRP procedures and forms the carrier distributes to covered persons.

14.0 Non-Retaliation

14.1 A carrier shall not disenroll, terminate or in any way penalize a covered person who exercises his rights to file a grievance, Petition for Arbitration or appeal for IHCAP review solely on the basis of such filing.

14.2 A carrier shall not terminate or in any way penalize a provider with whom it has a contractual relationship and who exercises, on behalf of a covered person, the right to file a grievance, Petition for Arbitration or appeal for IHCAP review solely on the basis of such filing.

15.0 Confidentiality of Health Information

15.1 Nothing in this Regulation shall supersede any federal or state law or regulation governing the privacy of health information.

16.0 Effective Date

16.1 This regulation shall become effective on April 11, 2007. Pursuant to the order of the Commissioner dated January 8, 2007, any claim filed for review or arbitration after January 8, shall be governed by this regulation. Any claim filed for review or arbitration prior to January 8, 2007 under the version of this regulation adopted February 15, 2002 and not resolved prior to January 8, 2007 shall be governed by the February 15, 2002 version of this regulation.

DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Sections 311 and 332 (18 Del.C. §§ 311 and 6401 *et seq.*)

18 DE Admin. Code 1403

PUBLIC NOTICE

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of proposed Department of Insurance **Regulation 1403** relating to **Managed Care Organizations**. The docket number for this proposed regulation is 357.

The Department of Insurance proposes to amend Regulation 1403 by rescinding the current regulation and substituting in lieu thereof revised provisions for the review and arbitration of health insurance claims. As a result of the enactment of Senate Bill 295 on July 6, 2005 it became necessary to re-promulgate Regulation 1301 to provide for the review of claims from managed care organizations formerly under the regulatory authority of the Department of Health and Social Services. The **Delaware Code** authority for the change is 18 **Del.C.** §§311 and 6401 *et seq.* The text can also be viewed at the Delaware Insurance Commissioner's website at www.delawareinsurance.gov and clicking on the link for "Proposed Regulations."

The Department of Insurance will hold a public hearing on the proposed changes on Monday, February 26, 2007 at 10:00 a.m. in the Consumer Services hearing room, 841 Silver Lake Blvd., Dover, DE 19904. Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed amendment. Any written submission in response to this notice and relevant to the proposed change must be received by the Department of Insurance no later than 4:30 p.m. March 6, 2007 by delivering said comments to Deputy Attorney General Michael J. Rich, c/o Delaware Department of Insurance, 841 Silver Lake Boulevard, Dover, DE 19904, or sent by fax to 302.739.5566 or emailed to michael.rich@state.de.us.

IT IS SO ORDERED this 8th day of January, 2007

Matthew Denn, Insurance Commissioner

1403 Health Maintenance Organizations [Formerly Regulation 58]

EXHIBITS:

- A. Form No. H-1—Application for License as a Health Maintenance Organization
- B. Form No. H-2—Admittance Questionnaire for Certificate of Authority
- C. Form No. H-3—Designation of Official Authorized to Appoint and Remove Agents
- D. Form No. H-4—Designation of Person to Receive Bulletins
- E. Form No. H-5—Designation of Person to Receive Service of Process
- F. Biographical Affidavit of Officers/Directors
- G. Power of Attorney Form

H. Rules and Regulations Governing the Application and Operation of Health Maintenance Organizations (State Board of Health)

Editorial Note: Copies of forms to be submitted by HMO's to the Delaware Insurance Department when making application for a certificate of authority follow Section 15 of Regulation No. 58.

1.0 Authority

This Regulation has been promulgated in accordance with 18 ~~Del.C.~~ Ch. 64 which provides authority for the Commissioner to regulate the insurance aspects, including financial solvency, of health maintenance organizations established or operated in this State.

2.0 Purpose

The purpose of this Regulation is to establish the criteria for licensing a health maintenance organization and to establish the procedure for obtaining and maintaining a certificate of authority.

3.0 Definitions

"Basic Health Services" means those services required by the Delaware Board of Health in their Regulation Governing the Application and operation of "Health Maintenance Organizations" hereinafter referred to as "Board of Health Regulations."

"Health Maintenance Organization" means a public or private organization, organized under the laws of any state, which:

- Provides or otherwise makes available to enrolled participants health care services including at least the basic health services defined in the Board of Health Regulation.
- Is primarily compensated (except for co-payment) for the provision of basic health care services to enrolled participants on a predetermined periodic rate basis; and
- Provides physicians' services directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

"Health Care Provider" means a hospital, nursing home, physician, clinic or laboratory or other person which enters into an agreement with a health maintenance organization to provide health services to its subscribers or enrollees.

"Agent" means a person who is appointed or employed by a health maintenance organization and who engages in solicitation of membership in such organization. This definition does not include a person enrolling members on behalf of an employer, union, or other organization to whom a master subscriber contract has been issued.

References in Regulation No. 58 to 18 ~~Del.C.~~ Ch. 64 §§6401. to 6406 may be located from page 725 of this volume; references to 16 ~~Del.C.~~ Ch. 91 §§9101 to 9115, pages 1638.01 to 1638.09. 18 ~~Del.C.~~ Ch. 64 is entitled Insurance Regulation of Health Maintenance Organizations; 16 ~~Del.C.~~ Ch. 91 is entitled Health Maintenance Organizations.

4.0 Certificate of Authority

4.1 No person may establish, operate, or engage in the business of a health maintenance organization, or enter this State for the purpose of enrolling persons in a health maintenance organization without first obtaining a certificate of authority from the Insurance Commissioner and a certificate of authority from the Department of Health and Social Services pursuant to 16 ~~Del.C.~~ Ch. 91. For purposes of this Regulation, the phrase "establish, operate or engage in the business of a health maintenance organization, or enter this State for the purpose of enrolling persons in a health maintenance organization" shall be defined in accordance with 18 ~~Del.C.~~ §103, "Transacting Insurance."

4.2 Every health maintenance organization established or in operation in this State on the effective date of this regulation must apply for and obtain a certificate of authority from the Insurance Commissioner in order to continue such operation. If such an operation files an application within ninety (90) days of the effective date of this regulation, it may continue its operation until the application is acted upon. If the application is denied, the applicant shall be treated as a health maintenance organization which has had its certificate of authority revoked under 18 ~~Del.C.~~ §6405.

4.3 At the time of adoption of this regulation, any HMO which does not meet the minimum capital and surplus requirements within the period established for submitting an application for a certificate of authority shall be permitted to operate for a period not to exceed six months if:

4.3.1 the subscribers/enrollees are adequately protected; and

4.3.2 the HMO is seeking additional sources of capitalization; and

4.3.3 there is a reasonable expectation that the HMO will meet the minimum capital and surplus standards within the six-month period.

5.0 Application Procedure

5.1 Each application for a certificate of authority as a health maintenance organization shall be made on Form No. H-1 entitled "Application for License as a Health Maintenance Organization," attached hereto as Exhibit A and incorporated herein. It shall be accompanied by a filing fee of \$500.00 and the following documents:

5.1.1 A copy of all documents filed under Part Two of the Board of Health Regulation;

5.1.2 Equifax Reports on Officers/Directors; and/or NAIC biographical or other similar biographical forms, as directed by the Department.

5.1.3 A statement identifying the states where the health maintenance organization is authorized to operate, any states where it has pending an application for authorization to operate; any states where it has been cited for a violation of any laws or legislation and an explanation of any such alleged violation, including status or outcome;

5.1.4 Copies of management, agency or administrative contracts;

5.1.5 Proof of \$50,000 bond for each officer, director, partner, who receives, collects or invests money;

5.1.6 Designation of official authorized to appoint and remove agents Form No. H-3 (See Exhibit G);

5.1.7 Designation of person to receive bulletins, regulations, etc. Form No. H-4 (See Exhibit D);

5.1.8 Designation of person to receive service of process Form No. H5 (See Exhibit E);

5.1.9 Biographical Affidavit of Officers and Directors (See Exhibit F);

5.1.10 Power of Attorney Form (See Exhibit G);

5.1.11 Deposit of \$100,000 in accordance with 16 ~~Del.C.~~ §9105 and 18 ~~Del.C.~~ §513(f);

5.2 All of the above referenced documents must be submitted in order for the Department to review an application.

6.0 Issuance of Certificate of Authority

6.1 The Commissioner shall issue a certificate of authority to an applicant within 60 days after filing a completed application and payment of the required fee, if he is satisfied of that:

6.1.1 The applicant meets or is able to meet the requirements of Chapter 64 of Title 18 and this regulation, as set forth herein;

6.1.2 Arrangements have been made by the applicant reasonably to assure provision of the services covered by its contracts; and

6.1.3 The applicant is financially responsible and able to meet its obligations to members.

6.1.4 Certificates of authority are issued on a permanent basis but must be continued annually on or before March 1 through the payment of an annual continuation fee of \$50.00.

7.0 Suspension or Revocation of Certificate of Authority

7.1 The certificate of authority of a health maintenance organization may be suspended by the Commissioner after a hearing, for any of the following causes:

7.1.1 If the Commissioner is satisfied, upon examination or from other evidence submitted to him, that any health maintenance organization is in an unsound financial condition, or that its business policies or methods are unsound or improper, or that its condition or management is such as to render its further transaction of business hazardous to the public or its members; or

7.1.2 The health maintenance organization has violated a provision of Chapter 64 of Title 18 or any of the chapters specified in 18 ~~Del.C.~~ §6406.

7.1.3 Upon notification by the Division of Public Health of suspension or revocation of the certificate of authority issued by the Division of Public Health.

8.0 Capital Funds Required

~~8.1 Each health maintenance organization that obtains a certificate of authority shall have and maintain unimpaired capital stock or unimpaired basic surplus of at least \$300,000 and free surplus of at least \$150,000 or the minimum capital and free surplus as may be required by legislative changes adopted by the General Assembly from time to time. The above capital and surplus requirements are in addition to the deposit requirements of 18 Del.C. §513(f).~~

~~8.2 Annually, at the time of filing the annual statement on March 1, each health maintenance organization which has a current certificate of authority shall demonstrate that it has maintained the minimum capital established by this regulation or subsequent legislative enactment. In addition to the minimum capital, a Health Maintenance Organization must demonstrate that it has provider contracts which require that the provider agrees in the event of non-payment by the HMO that the provider will not seek compensation or have any recourse against a subscriber/enrollee, as described in section 9.0.~~

9.0 Required Contractual Provisions

~~9.1 Every contract between a health maintenance organization, proposed, established or operating in this State and a health care provider (hereinafter referred to as "provider contracts"), shall include a provision substantially in the following form:~~

~~9.1.1 Provider agrees that in no event, including but not limited to non-payment by the HMO, insolvency of the HMO [or breach of this agreement] shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or persons (other than the HMO) acting on his/their behalf for services provided pursuant to this agreement. This provision does not prohibit the provider from collecting supplemental charges or co-payments or fees for uncovered services delivered on a "fee-for-service" basis to HMO subscribers/enrollees.~~

~~9.1.2 Provider agrees that this provision shall survive the termination [of this agreement] for authorized services rendered prior to the termination of this agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscribers/enrollees. This provision is not intended to apply to services provided [after this agreement] has been terminated.~~

~~9.1.3 Provider agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider and the subscriber, enrollee, or persons acting on their behalf insofar as such contrary agreement relates to liability for payment for services provided under the terms and conditions of this agreement."~~

~~9.2 Before issuing a certificate of authority authorizing an HMO to do business in Delaware, or permitting the continuation of an already authorized HMO, the Commissioner shall ascertain that the HMO has validly executed provider agreements with all providers and that the provider contracts contain the required protection for subscribers/enrollees. In the event that the HMO has not entered into such agreements with all providers, the HMO must demonstrate to the Commissioner's satisfaction that it has made a good faith effort to enter into these agreements. In lieu of these executed provider agreements, the Commissioner may, at this discretion, allow the HMO to engage in the business of a health maintenance organization if not already authorized, or continue to be engaged in the business of a health maintenance organization if previously authorized, if the HMO establishes reserves equal to 25% of the total projected annual incurred claims or benefits payments attributable to the provider which or who has not agreed to enter into a provider agreement.~~

10.0 Reinsurance Requirement

~~The health maintenance organization shall secure insurance reinsurance protection to provide to the health maintenance organization in the event of catastrophic or unusual losses which would be in excess of the levels of loss which the health maintenance organization assumes in the basis of its calculation of premium charges.~~

11.0 Special Requirement in the Event of Financial Impairment/insolvency

~~In the event of the financial impairment or insolvency of a health maintenance organization doing business in this State, as defined herein, each health maintenance organization doing business in this State shall permit a 60-day "open enrollment" period for existing subscribers of the impaired/ insolvent health maintenance organization to enroll in a solvent health maintenance organization. Each such solvent licensed health maintenance organization shall be required to accept within the "open enrollment" period any subscriber who~~

wishes to enroll at the rates or costs and benefits which are then in effect at the chosen HMO for the class or grouping represented by the enrolling subscriber. Each such solvent licensed HMO shall accept such enrolling subscriber without any waiting periods or pre-existing conditions exclusions and such acceptance both as to premium as well as delivery of service shall be retroactive to the date on which a court of competent jurisdiction has declared the predecessor HMO financially impaired.

12.0 Required Disclosure to Subscribers/Enrollees

All forms of evidence of coverage issued by the health maintenance organization to enrolled participants, or other marketing documents purporting to describe the organization's health care services, shall contain clear and complete information indicating (1) the health care services and other benefits to which the enrolled participant is entitled, (2) any exclusions or any limitations on services or any other benefits to be provided, including any deductible or co-payment feature or any restrictions relating to preexisting conditions, and (3) the names of all hospitals and primary care or other providers normally available to the participants/enrollees.

13.0 Other Applicable Provisions

13.1 Every health maintenance organization issued a certificate of authority in this State shall be treated for the purposes of the following chapters only, as a health insurer, and its coverages shall be deemed to be medical and hospital expense incurred insurance policies for the purposes of 18 ~~Del.C.~~ Ch. 25:

13.1.1	Chapter 1	General Definitions and Provisions.
13.1.2	Chapter 3	The Insurance Commissioner.
13.1.3	Chapter 5	Authorization of Insurers and General Requirements.
13.1.4	Chapter 9	Kinds of Insurance; Limits of Risk; Reinsurance.
13.1.5	Chapter 11	Assets and Liabilities.
13.1.6	Chapter 13	Investments.
13.1.7	Chapter 15	Administration of Deposits.
13.1.8	Chapter 17	Agents, Brokers, Consultants, etc.
13.1.9	Chapter 21	Unauthorized Insurers.
13.1.10	Chapter 23	Unfair Practices in the Insurance Business.
13.1.11	Chapter 25	Rates and Rating Organizations.
13.1.12	Chapter 27	The Insurance Contract.
13.1.13	Chapter 33	Health Insurance Contracts.
13.1.14	Chapter 34	Medicare Supplement Insurance Minimum Standards.
13.1.15	Chapter 35	Group and Blanket Health Insurance.
13.1.16	Chapter 36	Individual Health Insurance Minimum Standards.
13.1.17	Chapter 59	Subchapter I Rehabilitation and Liquidation.

14.0 Separability Provisions

If any provision of this regulation shall be held invalid, the remainder of the regulation shall not be affected thereby.

15.0 Effective Date

This regulation shall become effective 30 days from the date of signing.

Editorial Note: Forms to be submitted and certain instructional material begin on the next following page.

EXHIBIT A
STATE OF DELAWARE
DEPARTMENT OF INSURANCE
APPLICATION FOR
HEALTH MAINTENANCE ORGANIZATION
CERTIFICATE OF AUTHORITY

Application is hereby made by

PROPOSED REGULATIONS

Corporate Title

Corporate Address

Administrative/Mailing Address

Incorporated or Organized on _____, in _____
Date Domicile

as a _____ (stock, mutual, reciprocal, fraternal, mutual benefit, etc.) insurer for a Certificate of Authority to transact the business of insurance within the State of Delaware for the line of Accident and Health, as set forth in Title 18, ~~Del.C.~~

Federal Employer's Identification Number (EIN) _____

Corporate Title

By:

Title:

Date:

FORM NO. H-1

EXHIBIT B

STATE OF DELAWARE

DEPARTMENT OF INSURANCE

ADMITTANCE QUESTIONNAIRE FOR

CERTIFICATE OF AUTHORITY

OF HEALTH MAINTENANCE ORGANIZATION

The following data is being submitted to the Delaware Department of Insurance:

1. Company Name:

Home Office:

Contact Person:

Telephone No.:

2. Proposed location of principal place of business within State:

Address at which all books, accounts and documents relating to business in this State will be kept:

If applicant is a foreign proprietorship, partnership, or corporation, address of principal place of

business:

3. Applicant is: () Individual Proprietor

() Partnership

() Corporation

() Other (Specify)

4. If applicant is a corporation (Attached Certificate of Incorporation)

(a) State of Incorporation

(b) Date of Incorporation

(c) If a foreign corporation, name and address of Agent for Service of Process in Delaware:

5. If applicant has engaged previously in the same or a similar business; provide details, including name(s), address(es), and date(s) first commenced:

6. State whether applicant is, directly or indirectly, under common ownership, control, or management or is otherwise affiliated or associated with any insurer, or any person, firm or corporation having or exercising control of an insurer.

() Yes, supply complete details () No

7. If applicant is a partnership

(a) State whether general partnership or limited partnership:

(b) Give names and addresses of all partners specifically identifying limited partners, if any:

8. If applicant is a corporation, trust or other entity, other than a partnership, of which ownership is manifested by shares, identify each type of shares and state:

- (a) Number of shares authorized:
- (b) Number of shares outstanding:
- (c) Par Value:

(d) Give name, residence address, title and number and percent of shares directly or beneficially owned by every officer and director and every person, firm or corporation owning or controlling 10% or more of the shares of each type:

Name and Residence Address	Title	Number of Shares (%)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Attach current, certified financial statement, which is as of the following date:

10. If applicant, or any subsidiary, affiliated, or associated health maintenance organization, has more than one place of business, give the name and address of each:

11. If the appropriate answer is "Yes" to any of the following questions concerning the applicant, manager, any officer, director, owner or beneficial owner of 10% or more of the shares, complete details must be given, including name, address, disposition of charges, etc.

Have any of the above:

(a) Applied previously in this State for a license to engage in the business of a health maintenance organization?

Yes No

(b) Received a rejection, revocation or suspension of license under laws of this State governing a health maintenance organization?

Yes No

(c) Received a rejection, revocation or suspension of license under a health maintenance organization law or regulation, or similar law or regulation in any other State?

Yes No

Exhibit B concluded

(d) Received a revocation or suspension of any license, been convicted or entered a plea of guilty, or nolo contendere, with respect to any law of regulation relating to the business of insurance?

Yes No

(e) Been arrested, indicted, convicted, entered a plea of guilty or nolo contendere with respect to a State or Federal offense in this or nay other State?

Yes No

(f) Been placed in voluntary or involuntary bankruptcy, receivership, trusteeship, or conservatorship?

Yes No

(g) Do any of the above now hold a license to engage in the business of a health maintenance organization or a similar or related business in any State, District or Territory of the United States?

Yes No

AFFIDAVIT

County _____

State _____

I, _____, the undersigned being the _____

(Title, if a corporation)

of the _____

(Name of Health Maintenance Organization)

swear, (or affirm), that to the best of my knowledge and belief, the statements contained in this application, including the accompanying statements (if any), are true and complete.

By: _____

Title: _____

Subscribed and sworn to before me this _____ day of _____, 19_____.

PROPOSED REGULATIONS

Notary Public

FORM NO. H-2
EXHIBIT C
DEPARTMENT OF INSURANCE
STATE OF DELAWARE
LICENSE DIVISION
NOTICE OF POWER OF APPOINTMENT
AND

REMOVAL OF AGENTS LICENSED _____

To the INSURANCE COMMISSIONER of the State of Delaware:

(Name of Health Maintenance Organization)

of _____, in the State of _____, hereby constitutes and appoints

(Name of Appointee)

(Address)

whose signature appears below, with full power to appoint and remove agents for said Company within the State of Delaware and such appointment of said agents shall be as valid and binding as if made directly by the officers of said Company. This designation may be changed by a subsequent filing.

(Signature of Appointee)

WITNESS our hands and seal of the Company hereto attached this _____ day of _____, 19____.

(Signature)

(Title)

(SEAL)

EXHIBIT D
DEPARTMENT OF INSURANCE
STATE OF DELAWARE
DESIGNATION OF PERSON(S) TO RECEIVE
DELAWARE REGULATIONS, BULLETINS,
CIRCULAR LETTERS, AND NOTICE OF

REGULATORY PROCEEDINGS _____

To the Insurance Commissioner, State of Delaware:

(Name of Health Maintenance Organization)

hereby designates:

(Telephone) (_____) _____

(Name of Designee)

to receive, from the Delaware Insurance Department, copies of Regulations, Bulletins, circular Letters and Notice of Regulatory Proceedings when issued by the Department, at the following address:

WITNESS my hand and seal of the Company affixed hereto this _____ day of _____, 19____.

(Signature)

(Officer's Title)

(SEAL)

EXHIBIT E
DEPARTMENT OF INSURANCE
STATE OF DELAWARE
DESIGNATION OF PERSON FOR
RECEIPT OF SERVICE OF PROCESS

To the Insurance Commissioner of the State of Delaware:, pursuant to 18 Del.C. §524(e)

(Name of Health Maintenance Organization)

of _____ hereby-

(Administrative/Mailing Address)

designates _____ Telephone: () _____

(Name of Designee)

as the person to whom process served upon the Commissioner against the above cited company is to be forwarded. (If the address of the designee is other than reflected above, please provide the mailing address.)

WITNESS my hand and seal of the company this _____ day of _____, 19_____.

(Title of Officer)

(SEAL)

FORM NO. H-5
EXHIBIT F
BIOGRAPHICAL AFFIDAVIT

(Print or Type)

Full Name and Address of Company (Do Not Use Group Names):

In connection with the above named company, I herewith make representation and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE", SO STATE.

1. Affiant's Full Name (Initials Not Acceptable.)

2. a. Have you ever had your name changed? _____ If yes, give the reason for the change

b. Other names used at any time.

3. Affiant's Social Security Number.

4. Date and Place of Birth.

5. Affiant's Business Address.

Business Telephone.

6. List your residences for the last ten (10) years starting with your current address, giving:

DATE ADDRESS CITY AND STATE

7. Education: Dates, Names, Locations and Degrees.

College

Graduate Studies

Others

8. List memberships in Professional Societies and Associations.

9. Present or Proposed Position with the Applicant Company.

10. List complete employment record (up to and including present jobs, positions, directorates or officerships) for the past twenty (20) years, giving:

DATES EMPLOYER AND ADDRESS TITLE

11. Present employer may be contacted. Yes No (Circle One)

Former employers may be contacted. Yes No (Circle One)

PROPOSED REGULATIONS

12. a. Have you ever been in a position which required a fidelity bond?

If any claims were made on the bond, give details.

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond cancelled or revoked?

If yes, give details.

13. List any professional, occupational, and vocational licenses issued by any public or governmental licensing agency or regulatory authority which you presently hold or have held in the past (state date license issued, issuer of license, date terminated, reasons for termination).

14. During h last ten (10) years, have you ever been refused a professional, occupational, or vocational license by any public or governmental licensing agency or regulatory authority, or has any such license held by you ever been suspended or revoked?

If yes, give details.

15. List any insurers in which you control directly or indirectly or own legally or beneficially 10% or more of the outstanding stock (in voting power).

If any of the stock is pledged or hypothecated in any way, give details.

16. Will you or members of your immediate family subscribe to or own, beneficially or of record, shares of stock of the applicant insurance company or its affiliate?

If any of the shares or stock are pledged or hypothecated in any way, give details.

17. Have you ever been adjudged a bankrupt?

18. a. Have you ever been convicted or had a sentence imposed on suspended or had pronouncement of a sentence suspended or been pardoned for conviction of or pleaded guilty or nolo contendere to an information or indictment charging any felony, or charging a misdemeanor involving embezzlement, theft, larceny, or mail fraud, or charging a violation of any corporate securities statute or any insurance law, or have you been subject to any disciplinary proceedings of any federal or state regulatory agency?

If yes, give details.

Exhibit F Concluded

b. Has any company been so charged, allegedly as a result of any action or conduct on your part? If yes, give details.

19. Have you ever been an officer, director, trustee, investment committee member, key employee, or controlling stockholder of any insurer which, while you occupied any such position or capacity with respect to it, became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation or conservatorship?

20. Has the certificate of authority or license to do business of any insurance company of which you were an officer or director or key management person ever been suspended or revoked while you occupied such position?

If yes, give details.

Dated and signed this _____ day of _____ at _____.

_____. I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

(Signature of Affiant)

County _____

State _____

Personally appeared before me the above named _____

personally known to me, who, being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this _____ day of _____, 19____.

Notary Public

My Commission Expires _____

(SEAL)

EXHIBIT G

EXHIBIT H

Rules and Regulations Governing the Application and Operation of Health Maintenance Organizations
Adopted by the State Board of Health
on January 27, 1983, effective March 15, 1983
Revised July 1, 1989

Table of Contents

PART ONE

Legal Authority and Definitions

PART TWO

Application and Certificate of Authority

PART THREE

Quality Assurance and Operation of Health Maintenance Organizations

Hours of Service

Environmental Health and Safety

Housekeeping

Emergency Utilities or Facilities

Construction

Personnel

Health Services Information

Equipment

Specialized Services

Central Sterilizing and Supply

PART FOUR

Administrative Requirements

Administration

Qualifications

Medical Group Privileges

Peer Review

Medical Records

Reporting Requirements and Statistics

Departmental Reviews

Grievance Procedure

Variances

Exhibit A

PART ONE

Legal Authority and Definitions

A. ~~Legal Authority.~~ These regulations are adopted under Part VIII, Title 16, ~~Del.C.~~, Chapter 91, pursuant to delegation of authority from the Secretary of the Department of Health and Social Services to the Director of the Division of Public Health on December 22, 1982.

B. ~~Definitions.~~

1. ~~"Basic health services" means a range of services, including at least the following: usual physician services, hospitalization, laboratory, x ray, emergency and preventive services and out of area coverage.~~

~~Included under basic health services are the following:~~

a. ~~"Administrator/Director" means the individual employed to manage and direct the activities of the Health Maintenance Organization.~~

b. ~~Physician services, including consultant and referral services by a physician or other health care providers licensed by the State of Delaware.~~

c. ~~At least three hundred sixty (360) days of inpatient hospital services.~~

d. ~~Medically necessary emergency health services.~~

e. ~~Initial diagnosis and acute medical treatment (one (1) time only) and responsibility for making referrals (but not assuming financial responsibility) to appropriate ancillary facilities for the abuse of or addiction to alcohol and drugs.~~

f. ~~Diagnostic laboratory and diagnostic and therapeutic radiological services.~~

PROPOSED REGULATIONS

~~g. Preventive health services include the provision of physical examinations, Papanicolaou smears, immunizations, infertility services and children's eye examinations (through age 17), conducted to determine the need for vision correction performed at a frequency determined to be appropriate medical practice. Other preventive services may be provided by the Organization as contained in the Health Care Contract. The minimum level, scope and range of such services shall be determined by the Organization, subject to the approval of the State Board of Health.~~

~~h. The Organization should encourage, and actively provide, or arrange for, its members health education services, education in the appropriate use of health services and education in the contribution each member can make to the maintenance of his own health. This information, in whatever form it may take, must be in the opinion of the State Board of Health, understandable and not misleading.~~

~~i. Emergency out-of-area coverage.~~

~~2. "Supplementary health services" means any health services other than basic health services which may be provided by an Organization to its members and/or for which the member may contract such as:~~

~~a. ICF or long term care;~~

~~b. vision care not included in basic health services;~~

~~c. dental services;~~

~~d. mental health services;~~

~~e. long term physical medicine or rehabilitative services;~~

~~f. prescription health services; and~~

~~g. other services, such as occupational therapy, nutritional, home health, homemaker and family planning services.~~

~~3. "Certified Health Maintenance Organization" means a Health Maintenance Organization which has been issued a Certificate of Authority under 16 ~~Del.C. 21~~, or which is operating pending action as provided in 16 ~~Del.C. 21~~(b).~~

~~4. "Department" means the Delaware Department of Health and Social Services.~~

~~5. "Health Maintenance Organization" (HMO) means a public or private organization organized under the laws of any state, which:~~

~~(i) provides or otherwise makes available to enrolled participants health care services, including at least the basic health services defined in 1. above;~~

~~(ii) is compensated (except for co-payment) for the provision of basic health services to the enrolled participants on a predetermined periodic rate basis; and~~

~~(iii) provides physician services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).~~

~~6. "Insurance Department" means the Delaware Insurance Department.~~

~~7. "Member" means an individual and/or family who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into with the Organization, under which the Organization assumes the responsibility to provide to such person(s) basic health services and such supplemental health services as are enumerated in the Health Care Contract.~~

~~8. "Health care professional" means individuals engaged in the delivery of health services as licensed by the State of Delaware.~~

~~9. "Office" means any facility where members receive primary care and/or other health services.~~

~~10. "Certificate of Authority" means the authorization by the department of Health and Social Services to operate an HMO and this certificate shall be deemed to be a license to operate such an Organization.~~

~~11. "Commissioner" means the Insurance Commissioner of Delaware.~~

~~12. "Health care contract" refers to any agreement between an Organization and a member or group which sets forth the services to be supplied to the member in exchange for payments made by the member.~~

~~13. "Premium" refers to payment(s) called for in the Health Care Contract which must be:~~

~~a. paid or arranged for by, or on behalf of, the member before health care services are rendered by the Organization;~~

~~b. paid on a periodic basis without regard to the date on which health services are rendered; and~~

~~c. with respect to an individual member are fixed without regard to frequency, extent or cost of health services actually furnished.~~

14. "~~Supplemental payment~~" refers to any payment not incorporated in premium which is required to be paid to the Organization or providers under contract to the Organization by the member.

15. "~~Geographical area~~" refers to the stated primary geographical area served by an Organization. The primary area served shall be a radius of not more than thirty (30) miles or more than forty (40) minutes driving time from each office operated or contracted by the Organization. Members recruited outside the primary service area must receive special arrangements to be approved by the Director. In non metropolitan areas, i.e., not containing a city of over fifty thousand (50,000) persons, the limits of the primary service areas may be larger, but will be subject to approval of the Director.

16. "~~Out-of-area coverage~~" refers to health care services, as specified in the Health Care Contract, provided outside the Organization's geographic service area with appropriate limitations and guidelines acceptable to the Director and the Commissioner. As a minimum, such coverage must include emergency care.

17. "~~Comprehensive health planning agencies~~" refers to those agencies which have the responsibility for the planning and review of health facilities, resources and services under the State or Federal authority.

18. "~~Special services~~" refers, but is not limited to, the following services:

a. ~~Pharmacy services.~~ Pharmaceutical services, when provided by the Organization or its provider's staff, must be under the direct supervision of a registered pharmacist who is responsible to the administrative staff for developing, coordinating and supervising all pharmaceutical services; or, in the case of dispensing of pharmaceuticals by a physician, such dispensing shall not violate the requirements of State law. Organizations with a licensed pharmacy shall have a Pharmacy and Therapeutics Committee. Pharmaceutical services may be provided on the premises of the Organization or by contract with an independent licensed provider. The contract shall be available for inspection by the Director at all times.

b. ~~Clinical laboratory services.~~ All clinical laboratories operated by the Organization must have a director who is a physician or a person formally trained in a clinical laboratory field (i.e., biochemistry), as approved by the Director and who is qualified by training and experience to supervise and conduct the work of the clinical laboratory. If the laboratory director is not a qualified pathologist, the services of a pathologist so qualified shall be retained on a consultative basis to confer with the laboratory director and/or members of the medical staff on a periodic basis acceptable to the Director. If an Organization uses or controls a laboratory which performs limited services as defined by the Director, the Director shall have the authority to determine whether the laboratory is subject to this provision.

c. ~~Radiology services.~~ The Organization's radiology services shall be supervised and conducted by a qualified radiologist, either full time or part time; or, when radiology services are supervised and conducted by a physician who is not a qualified radiologist, the Organization shall provide for regular consultation by a qualified radiologist, who is under contract with the Organization and is responsible for reviewing all x-rays and procedures. The number of qualified radiological technologists employed shall be sufficient to meet the Organization's requirements. If the Organization operates a radiology service and provides emergency services, at least one qualified technologist shall be on duty or on call at all times. The Director may exempt an Organization where the method and personnel used to deliver radiology and/or emergency services warrant it.

PART TWO

Application and Certificate of Authority

A. ~~No person shall establish or operate an HMO in the State of Delaware or enter this State for purposes of enrolling persons in an HMO without obtaining a "Certificate of Authority." A foreign corporation shall not be eligible to apply for such certificate unless it has first qualified to do business in the State of Delaware as a foreign corporation pursuant to 8 Del.C. §371.~~

B. ~~Every HMO which is established or operating in this State on the effective date of these regulations must apply for and obtain a Certificate of Authority in order to continue such operation.~~

C. ~~Each application for a Certificate of Authority shall be made in writing to the Department of Health and Social Services, Division of Public Health, shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Department (Exhibit A attached) and shall set forth or be accompanied by the following:~~

~~1. Organizational Information~~

~~a. Brief history and description of current status of applicant, including an organization chart;~~

b. A copy of the basic organizational document of the applicant and all amendments thereto;

c. A list of the names, addresses and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant. Include all members of the Board of Directors or other governing board, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association; and

d. A list of positions, names and brief resume for all management personnel.

2. Health Services Delivery

a. A description of the plan of operation of the HMO. Include the following items: a listing of basic and supplemental health services with utilization projections; a discussion of the arrangements for delivery of all covered health services (including indications as to whether outpatient services are provided directly or through referrals/purchase agreements with outside fee for service providers); a general description of service sites or facilities (specifying days and hours of operation in the case of outpatient facilities); a discussion of special policies or provisions designed to improve accessibility of services;

b. Copies of executed contracts or letters of agreement between the HMO and providers, including individual physicians, IPAs, group practices, hospitals, laboratory services, nursing homes, home health agencies, and so on. In addition, copies of executed contracts or letters of agreement between an IPA or medical group and its member or non member physicians and other health professionals;

c. A list of participating (plan) physicians by specialty as well as a list of other health care personnel providing services. Provide staffing ratios for each category of personnel;

d. A list of facilities that show the capacity, square footage, and the legal arrangements for use of the facility (leases, subleases, contract of sale, etc.). Provide copies of leases, contracts of sale, or other legal agreements relating to the facilities to be operated by the HMO;

e. A description of the applicant's utilization control and quality assurance mechanisms, including information on committee structures, criteria, and procedures for corrective action; and

f. A discussion of the arrangements for assuring continuity of care for all services provided to enrollees. Include comments on the primary care physician's responsibilities for coordination and oversight of the patient's overall health care and the impact of the medical record keeping system on continuity of care.

3. Enrollment and Marketing

a. A brief description of the target population, including projections of enrollment levels for at least the first three (3) years of operation and the key assumptions (such as, assumed penetration rate) underlying these projections;

b. A description of the geographic area to be served, with a map showing service area boundaries, locations of the HMO's institutional and ambulatory care facilities, and travel times from various points in the service area to the nearest ambulatory and institutional services; and

c. A description of the proposed marketing techniques and sample copies of any advertising or promotional material.

4. Financial

a. A financial statement for the most recent fiscal year (certified by C.P.A. when possible).

b. Financial projections for a minimum of three (3) years. If deficits are anticipated, the projections should cover the period up to and including the year in which break even is expected. Include projections of revenue and expenses; a projected balance sheet; a pro forma cash flow statement; and a pro forma statement of changes in financial position. Indicate the assumptions on which statements are based, including inflation and utilization assumptions;

c. Sources of financing (private and governmental) and, where appropriate, written assurances of the availability of financing;

d. A description of reinsurance arrangements or risk sharing arrangements with providers; and

e. The proposed premiums for all classes of enrollee, co-payments, and the rating plan or rating rules used by the applicant.

D. Within sixty (60) days of receipt of application for issuance of Certificate of Authority the Department, acting through the Division of Public Health, shall determine whether the applicant, with respect to health care services to be furnished, has:

~~1. demonstrated the ability to provide such health services in a manner assuring availability, accessibility and continuity of services;~~

~~2. arrangements for an ongoing health care quality assurance program;~~

~~3. the capability to comply with all applicable rules and regulations promulgated by the Department;~~

~~4. the capability to provide or arrange for the provision to its enrollees of basic health care services on a prepaid basis through insurance or otherwise, except to the extent of reasonable requirements of co-payments; and~~

~~5. the staff and facilities to directly provide at least half of the outpatient medical care costs of its anticipated enrollees on a prepaid basis.~~

~~E. The Department shall issue a Certificate of Authority to any person filing an application under this section within sixty (60) days of receipt of such application if:~~

~~1. The application contains all the information required under C. of this Part;~~

~~2. The Department has not made a negative determination pursuant to D. of this Part; and~~

~~3. Payment of the application fees prescribed in 16 ~~Del.C.~~ 9114 has been made.~~

~~F. If within sixty (60) days after an application for a Certificate of Authority has been filed, the Department has not issued such Certificate, the Department shall immediately notify the applicant in writing of the reasons why such Certificate has not been issued and the applicant shall be entitled to request a hearing on the application. Such requests for hearing must be filed with the Division of Public Health within sixty (60) days of the notification of nonapproval of the application. The hearing shall be held within sixty (60) days of the receipt of written request. Hearings shall be conducted in accordance with applicable laws and regulations.~~

~~G. No Certificate of Authority shall be issued until there is first filed with the Department a certification by the Insurance Commissioner of Delaware that a deposit has been made, and is being maintained, in accordance with the terms and conditions of 18 ~~Del.C.~~ 513(f).~~

~~The required deposit shall be continuously maintained in trust. In case of a deficiency of deposit, the Insurance Commissioner shall transmit notice thereof to both the HMO and the Department. In case the deficiency is not cured within the allowed time, the Commissioner shall give notice thereof to the Department and the Department shall revoke its Certificate of Authority to the HMO.~~

~~H. Every HMO operating in this State shall file with the Department every manual, minimum, class rate, rating schedule, or rating plan and every other rating rule and every modification of any of the foregoing which it proposes to use. Every filing shall indicate the effective date thereof.~~

~~I. Annual reports shall be filed with the Department by any HMO on or before July 1 covering the preceding fiscal year. Such reports shall include a financial statement of the Organization, its balance sheet and receipts and disbursements for the preceding fiscal year, and a statement explaining any material changes in the information originally submitted.~~

~~J. Prohibited Practices.~~

~~1. No HMO or representative may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading; and~~

~~2. No HMO may cancel or refuse to renew the enrollment of an enrollee solely on the basis of his or her health. This does not prevent the HMO from cancelling the enrollment of a member if misstatements of his/her health were made at the time of enrollment, or prevent the HMO from cancelling or refusing to renew enrollment for reasons other than an enrollee's health including without limitation, nonpayment of premiums or fraud by the member.~~

~~K. A certified HMO may solicit enrollees and sell its services by its own employees, persons licensed to sell health insurance, or licensed or permitted to sell the benefit program of a health service corporation.~~

~~L. Relationships with Insurance Companies and Health Service Corporations.~~

~~Any person or corporation authorized to transact insurance or to engage in the business of a health service corporation in this State, may either directly or through a subsidiary or affiliate, operate an HMO subject to the provisions of 16 ~~Del.C.~~ ¶ 91. In addition, no provision of the Insurance Code shall bar such person or corporation from contracting with an HMO to provide insurance, reinsurance or similar protection for such HMO against the cost of care provided through the HMO and to provide coverage in the event of the failure of the HMO to meet its obligations.~~

~~M. Examinations.~~

PROPOSED REGULATIONS

1. The Department may make examinations concerning the quality of health care services of any HMO. The Department may make such examination as it deems necessary for the protection of the interests of the enrollees of the HMO, but not less frequently than every three (3) years;

2. Every HMO shall submit its books and records relating to health care services to such examinations. In the course of such examinations, the Department may administer oaths to and examine the officers and agents of the HMO and of any health care providers with which it has contracts, agreements or other arrangements;

3. The reasonable expenses of examinations under this section shall be assessed against the organization being examined and remitted to the Department; and

4. In lieu of such examination of an out-of-state HMO the Department may accept the report of a similar examination made by the appropriate agency of another state; provided that if the HMO delivers health care services in this State, such report from another state shall not relieve the Department of its responsibility to make its own examination.

N. Suspension or Revocation of Certificate of Authority.

1. The Department may revoke or suspend a Certificate of Authority issued to an HMO pursuant to 16 ~~Del.C.~~ ~~§~~ 91, or may place an HMO on probation for such period as it determines, or may publicly censure an HMO if it determines, after a hearing, that:

a. The HMO is operating in a manner which deviates substantially, in manner detrimental to its enrollees, from the plan of operation described by it in securing its Certificate of Authority;

b. The HMO does not have in effect arrangements to provide the quantity and quality of health care services required by its enrollees;

c. The HMO is no longer in compliance with the requirements of 16 ~~Del.C.~~ ~~§~~ 9104(b); or

d. The continued operation of the HMO would be detrimental to the health or well-being of its enrollees needing services.

2. Proceedings in regard to any hearing held pursuant to this section shall be conducted in accordance with provisions for case decisions as set forth in the Administrative Procedures Act, 29 ~~Del.C.~~ ~~§~~ 101, and any applicable rules and regulations of the Department. Any decision rendered following a hearing shall set forth the findings of fact and conclusions of the Department as to any violations of this Chapter, and shall also set forth the reasons for the Department's choice of any sanction to be imposed. The Department's choice of sanction shall not be disturbed upon appeal, except for abuse of discretion;

3. Suspension of a Certificate of Authority pursuant to this section shall not prevent an HMO from continuing to serve all its enrollees as of the date the Department issues a decision imposing suspension, nor shall it preclude thereafter adding as enrollees newborn children or other newly acquired dependents of existing enrollees. Unless otherwise determined by the Department and set forth in its decision, a suspension shall, during the period when it is in effect, preclude all other new enrollments and also all advertising or solicitation on behalf of the HMO other than communication, approved by the Department, which are intended to give information as to the effect of the suspension.

4. In the event that the Department decides to revoke the Certificate of Authority of an HMO the decision so providing shall specify the time and manner in which its business shall be concluded. If the Department determines it is appropriate, it may refer the matter of conservation or liquidation to the Insurance Commissioner, and he shall then proceed in accordance with 18 ~~Del.C.~~ Ch. 59. In any case, after the Department has issued a decision revoking a Certificate of Authority, unless stayed in connection with an appeal, the HMO shall not conduct any further business except as expressly permitted in the Department's decision and it shall engage only in such activities as are directed by the Department or are required to assist its enrollees in securing continued health care coverage.

O. Regulation and Administrative Procedures.

The Department shall have authority to promulgate such reasonable rules and regulations as are necessary to carry out the provisions of this Chapter. Such rules and regulations shall conform to and be promulgated pursuant to the Administrative Procedures Act, 29 ~~Del.C.~~ Ch. 101.

P. Fees.

Every HMO subject to this Chapter shall pay the following fees.

1. For filing an application for a Certificate of Authority—\$375.00.

2. For filing an annual report—\$250.00.

Q. Relationship to Other Laws.

1. Except as provided in 5. below, a certified HMO shall not be deemed to be practicing medicine and the HMO shall be exempt from the provisions of statutes, rules and regulations relating to the practice of medicine;

2. No HMO delivering health care services in this State shall engage in a contract with or employ, for the delivery of such services, any person who does not hold a Delaware license to practice the profession for which such person is engaged or employed, if such practice requires a license; and

3. Except as provided in 16 ~~Del.C.~~, 9108 or 9109, solicitation of enrollees by a certified HMO or its employees shall not be construed as a violation of any statute, rule or regulation relating to solicitation or advertising by health professionals.

4. The provisions of Title 18 and other laws of this State relating to insurance, insurance contracts, insurance policies, insurers or health service corporations shall not be applicable to any certified HMO. If an insurer or health service corporation operates a certified HMO only the activities related to the operation of the certified HMO shall be exempt from the provisions of such laws relating to insurers or health service corporations.

5. Notwithstanding 1. and 4. of this section, every HMO shall be a health care provider within the meaning of the Health Care Malpractice Insurance and Litigation Act, 18 ~~Del.C.~~, Ch. 68.

6. Issuance of a Certificate of Authority pursuant to 9104 shall be deemed licensure by the State Board of Health for purposes of the Delaware Health Facilities Act, 16 ~~Del.C.~~, 9703(5).

R. Confidentiality of Health Information.

Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from such person or from any health care provider by any HMO shall be held in confidence and shall not be disclosed to any person except upon the express consent of the enrollee or applicant, or his physician, or pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of claim or litigation between such person and the HMO wherein such data or information is pertinent. The communication of such data or information from a health care provider to an HMO shall not prevent such data or information from being deemed confidential for purposes of the Delaware Uniform Rules of Evidence.

S. Freedom of Choice.

In order to promote freedom of choice by employers and others in Delaware who purchase group health care coverage, it shall be unlawful, from and after thirty (30) days following the effective date of this enactment, for any insurer, health service corporation, or other person in the business of providing or insuring health care services or coverage, to offer any insurance or health care coverage to any person in this State on a basis which would preclude such person from allowing some members of a group to elect to enroll in a certified HMO either by means of an express prohibition or by requiring the same payment regardless of such election; provided, however, that it shall not be unlawful for such persons to offer insurance or coverage on a basis where the rates or cost thereof are calculated according to the number of persons in the group for which such coverage is provided. The Insurance Department shall have authority to enforce the provisions of this section.

PART THREE

Quality Assurance and Operation of Health Maintenance Organizations

The guidelines contained in this Part shall be enforced by the State Board of Health in a manner which facilitates an Organization's compliance thereto. Variations in the requirements of this Part may be approved at the discretion of the State Board of Health.

A. Hours of Service

1. The Organization must provide clinical services six (6) days a week for a total of forty (40) hours with no less than three (3) hours on any given day, unless otherwise approved by the State Board of Health.

2. Emergency services must be available twenty four (24) hours per day and seven (7) days per week.

a. The Organization shall have a well defined, written plan for the availability of twenty four (24) hour emergency care, which as a minimum makes provision for the assessment and treatment or referral to an appropriate facility.

b. These plans must be reviewed annually. When changes are made, a plan acceptable to the Board must be on file.

c. The Board may waive the radius for emergency services if the services are adequate.

d. When the Organization provides its own emergency services, facilities must be provided to ensure prompt diagnosis and emergency treatment: this includes adequate Emergency Room space,

separate from major surgical suites. In Emergency Room facilities provided for or arranged for by the Organization there shall be as a minimum: adequate oxygen, suction, CPR, diagnostic equipment, as well as standard emergency drugs, parenteral fluids, blood or plasma substitutes and surgical supplies. Radiology facilities, clinical laboratory facilities and current toxicology including antidotes information shall be available at all times.

e. Personnel shall be trained and approved by an appropriate professional organization in the operation and procedures of emergency equipment.

B. Environmental Health and Safety

1. Office premises and other structures operated by the Organization must have appropriate safeguards for patients.

2. All buildings shall conform to all State and medical codes and all regulations applicable to services being offered. These codes shall include but are not limited to:

a. State Plumbing Code.

b. Waste Disposal Regulations.

c. Public Water Supply Regulations.

d. Food Service Requirements.

e. Radiation Control Regulations.

f. Hazardous Waste Regulations.

g. Air and Water Pollution Regulations.

h. Handwashing facilities shall be installed in accordance with applicable State and local regulations and conveniently located.

i. Toilet facilities shall meet appropriate State and local regulations.

j. Must meet the requirements of the State Fire Code.

3. The buildings must be architecturally accessible to handicapped individuals.

4. Measures must be taken to insure that facilities are guarded against insects and rodents.

C. Housekeeping

1. A housekeeping procedures manual shall be written and followed. Special emphasis shall be given to procedures applying to infectious diseases or suspect areas.

2. All premises shall be kept neat, clean, free of litter and rubbish.

3. Walls and ceilings shall be maintained free of cracks, falling plaster and shall be cleaned and painted regularly.

4. Floors shall be cleaned regularly and in such a manner that it will minimize the spread of pathogenic organisms in the atmosphere; dry dusting and sweeping shall be prohibited.

5. Suitable equipment and supplies shall be provided for cleaning all surfaces.

6. Solutions, cleaning compounds and hazardous substances shall be properly labeled and stored in safe places.

D. Emergency Utilities or Facilities

1. The Organization shall be equipped to handle emergencies due to equipment failures. Emergency electrical service for lighting and power for equipment essential to life safety shall be provided in accordance with hospital regulations where appropriate. (Minimum Requirements for Construction and Equipment for Hospitals and Medical Facilities, Section 7.32H. (4)(b).)

2. In facilities which provide hospital services, the emergency electrical system shall be so controlled that the auxiliary power is brought to full voltage and frequency and be connected within ten (10) seconds.

3. Emergency utilities for Organizations and contract providers must be supplied according to procedures performed on the premises.

E. Construction

1. New construction or substantial modifications on an existing organization facility shall conform to applicable State, county and local codes, including the National Fire Protection Association Publication No. 101 Life Safety code, latest edition adopted by the State Fire Prevention Board.

2. Radiation requirements of the Authority on Radiation Protection must be met.

3. Facility plans or modifications must be submitted in the required manner.

F. Personnel

1. The office shall be staffed by appropriately trained personnel. Appropriate manuals shall be developed to serve as guidelines and set standards for patient care provided by non professional personnel.

~~2. Offices with five (5) or more physicians shall have at least one (1) full-time registered nurse (R.N.). The HMO may as an alternative, subject to the approval of the Director of the Division of Public Health, employ a licensed practical nurse (L.P.N.) and retain a licensed R.N. as a consultant.~~

~~3. Non-professional personnel shall have appropriate in-service education on clinical operations and procedures. The in-service training program must be conducted at least annually and be approved by the State Board of Health.~~

~~4. Primary physicians. There shall be at least one (1) full-time or full-time equivalent physician available on contract. There shall be at least 0.5 full-time equivalent primary physician for every 1,000 members enrolled.~~

~~5. Medical specialties. There shall be either full-time or part-time physicians, other appropriate professional specialists, or written agreements acceptable to the State Board of Health for consultation in internal medicine, pediatrics, general surgery, oral surgery, ENT, obstetrics and gynecology, orthopedic surgery, ophthalmology, pharmacy, radiology, physical therapy, psychiatry, nutrition and other reasonable services.~~

~~G. Health Services Information~~

~~Health services information shall be available to members and staff before and during enrollment periods. This should be understandable and not misleading.~~

~~H. Equipment~~

~~Each office operated by the Organization must have the necessary equipment and instruments to provide the required services. Equipment and instruments for services, when covered by written contract with medical specialists or other providers outside of the office, need not be present in the Organization's office. Where emergency services are provided in the office, equipment such as a defibrillator, laryngoscope and other similar equipment must be present.~~

~~I. Specialized Services~~

~~The Organization shall provide special services necessary for diagnosis and treatment such as electrocardiography. Where it is not feasible to provide these services in the office, there shall be a written agreement for these services in a nearby location except for isolated rural areas where arrangements for these services shall be subject to review and approval by the Board.~~

~~J. Central Sterilizing and Supply~~

~~Autoclaves or other acceptable sterilization equipment shall be provided of a type capable of meeting the needs of the Organization and of a recognized type with approved controls and safety features. Bacteriological culture tests shall be conducted at least monthly. The maintenance program of the sterilization system shall be under the supervision of competent trained personnel.~~

PART FOUR

Administrative Requirements

A. Administration

~~The Organization shall designate or assure the designation of appropriate person(s) to handle the administrative functions of the Organization. These functions shall include the following responsibilities: interpretation, implementation and application of policies and programs established by the Organization's governing authority; establishment of safe, effective and efficient administrative management; control and operation of the services provided; authority to monitor or supervise the operation of the office(s) in a manner acceptable to the Organization and in accordance with acceptable medical standards; and such other duties, responsibilities and tasks as the governing body or other designated authority may empower such individual(s).~~

~~B. Qualifications~~

~~Persons appointed to administrative positions in the Organization shall have the necessary current training and/or experience in the field of health care as appropriate to carry out the functions of their job descriptions.~~

~~C. Medical Group Privileges~~

~~The physicians who are under contract, either full-time or part-time, shall have hospital privileges commensurate with their contractual obligations. Physicians must be licensed in Delaware in Medicine and Surgery and in all their branches. All offered medical specialty services must be covered either by the privileges of the full-time or part-time physicians or qualified medical specialists under written contract to the Organization.~~

~~D. Peer Review~~

PROPOSED REGULATIONS

The Organization shall show written evidence of continuing internal peer review which compares with generally accepted standards in the field of utilization review. This entails an ongoing quality assurance program for its health services and provides review by physicians and other health professionals of the process followed in the provision of health services.

1. The review program shall include the following:
 - a. a description of the method of review;
 - b. the goals of the review;
 - c. the standards used for comparative purposes; and
 - d. the results of the application of the above process.

2. In lieu of the internal peer review, the Organization may elect to satisfy this requirement by contracting with an outside peer review organization approved by the State Board of Health. The organizational methodology and results of this contractual program must be on file.

E. Medical Records

The Organization must maintain or provide for the maintenance of a medical records system which meets the accepted standards of the health care industry and necessary regulations of the State Board of Health.

1. These records shall include the following information: name, identification number, age, sex, residence, employment, patient history, physical examination, laboratory data, diagnosis, treatment prescribed and drugs administered.

2. The medical record should also contain an abstract summary of any inpatient hospital care or referred treatment.

3. Regulatory agencies shall have access to medical records for purposes of monitoring and review of HMO practices with appropriate safeguards for individual confidentiality.

4. Clients' records shall be filed for five (5) years following active status before being destroyed.

F. Reporting Requirements and Statistics

The Organization shall submit reports, applicable to the State Board of Health, as required by these regulations and such generally applicable reports as requested. Reports on the individual operation of an Organization shall be submitted as reasonably required by the Department.

1. The Organization shall also provide in accordance with these regulations (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling and evaluating statistics as well as other information.

2. The Organization shall disclose to its members the following information:

- a. the cost of its operation;
- b. the patterns of utilization of its services based on the information in 3. below; and
- c. the location and hours of its inpatient and outpatient health services.

3. The following statistics are required to be submitted to the Department on an annual basis:

- a. Physician visits per member per year.
- b. Hospital admissions per year and per 1,000 members per year.
- c. Hospital days per year and per 1,000 members per year.
- d. Average length of stay per hospital confinement.
- e. Outside consultations per year and per 1,000 members per year.
- f. Emergency Room visits per year and per 1,000 members per year.
- g. Laboratory procedures per year and per 1,000 members per year.
- h. X ray procedures per year and per 1,000 members per year.

4. The following will also be submitted to the Department annually:

- a. Total number of members at the end of the year.
- b. Total number of members enrolled during the year.
- c. Total number of members terminated during the year.

5. The following administrative reports are required by the Department whenever there is a

change:

- a. Full name of the Administrator.
- b. Full name of the Medical Director.
- c. Address(es) of the office(s) in operation.
- d. Name(s) of the hospital(s) used by the Organization.

G. Departmental Reviews

1. ~~External Medical Audit~~

~~The Organization shall be subject to annual audits for the quality of the medical assurance system. The Organization shall provide the necessary data for the external audit as outlined by the Department. Where a Professional Standards Review Organization (PSRO) exists in the area, the Organization may contract with PSRO to provide periodic audits as to the quality of the medical assurance system.~~

2. ~~Fiscal Examinations~~

~~The Commissioner may make an examination of the operation of any Organization as often as he deems it necessary for the protection of the interests of the people of the State of Delaware, but such examinations shall not be less frequently than once every three (3) years. Fiscal examinations shall be limited to the Organization's records of its operation unless the Commissioner deems it necessary to examine the records of providers pursuant to their services to the Organization.~~

~~The expenses of examinations shall be assessed against the Organization being examined and such Organization shall remit the expenses to the Commissioner.~~

H. ~~Grievance Procedure~~

~~The Organization shall have an approved written grievance program which shall be available to its members as well as to any medical group or groups and other health delivery entities providing health services for the Organization. Copies of the procedures and a method of initiating a grievance shall be posted in a conspicuous place in all offices and sent to each member or member family unit when they are enrolled and each time the methods and procedures are substantially changed. The Organization shall designate to whom the grievance should be directed with an alternate person if the grievance involves the designated person.~~

~~1. Each grievance shall be answered in writing within thirty (30) days of submittal with the reply directed to the member(s) with the grievance.~~

~~2. Every Organization shall provide a reasonable procedure for handling grievances initiated by members and the recording of information related thereto in a form which may be readily reviewed by the Board of the Organization.~~

~~3. All grievance files shall be retained by the Organization for the Commissioner's and/or Department's examinations.~~

~~4. The Organization must notify the member whose grievance they cannot resolve that he may take his grievance to the Board of Directors.~~

I. ~~Variances~~

~~A variance from the requirements of these regulations may be granted by the State Board of Health as the Board deems appropriate; provided, however, that such variance shall be within the spirit of these regulations and not contrary to law.~~

Exhibit A

STATE OF DELAWARE

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

HMO APPLICATION FOR A CERTIFICATE OF AUTHORITY

A. ~~Identifying Information:~~

~~(1) Name of Applicant:~~

~~(1.1) Address:~~

~~(1.2) Telephone~~

~~(1.3) Zip Code:~~

~~(2) Chief Executive Officer:~~

~~(3) Type of Organization: (Check One)~~

~~() Staff~~

~~() Group Practice~~

~~() Individual Practice Association~~

~~() Other (Please describe)~~

~~(4) Anticipated date of operation:~~

B. ~~Statement of Certification and Acknowledgement:~~

PROPOSED REGULATIONS

~~I certify that the statements made in this application are accurate, complete, and current to the best of my knowledge and belief. I understand that this application does not relieve me of any responsibility under Part VIII, Title 16, Chapter 93 of the **Del.C.** (Certificate of Need).~~

~~Signature of Chief Executive Officer Date~~

~~A filing fee of \$375.00, payable to the Division of Public Health, must accompany this application. An original and two (2) copies of the application shall be submitted to:~~

~~Division of Public Health
Department of Health and Social Services
Jesse S. Cooper Memorial Building
Federal and Water Streets
Dover, Delaware 19904~~

1.0 Purpose and Statutory Authority

1.1 The purpose of this Regulation is to implement 18 **Del.C.** Ch. 64, as amended effective July 6, 2006, which transferred regulatory authority over Managed Care Organizations from the Department of Health and Social Services to the Department of Insurance. This Regulation is promulgated pursuant to 18 **Del.C.** §6408 and 29 **Del.C.** Ch. 101.

2.0 Definitions

The following words and terms, when used in this regulation, should have the following meaning unless the context clearly indicates otherwise:

“Adverse determination” means a decision by an MCO to deny (in whole or in part), reduce, limit or terminate benefits under a health care contract.

“Appeal” means a request for external review of an MCO’s determination resulting in a denial, termination or other limitations of covered health services based on medical necessity or appropriateness of services

“Appropriateness of services” means an appeal classification for adverse determinations that are made based on identification of treatment as cosmetic, investigational, experimental or not an appropriate or preferred treatment method or setting for the condition for which treatment is sought.

“Balance billing” means a health care provider’s demand that a patient pay a greater amount for a given service than the amount the individual’s insurer, managed care organization, or health service corporation has paid or will pay for the service.

“Basic Health Services” means a range of health care services, including at least the following:

A. Physician services, including consultant and referral services, by a physician licensed by the State of Delaware;

B. At least 365 days of inpatient hospital services;

C. Medically necessary emergency health services;

D. Diagnostic laboratory services;

E. Diagnostic and therapeutic radiological services;

F. Preventive health services; and

G. Emergency out-of-area and out-of-network coverage.

“Carrier” means any entity that provides health insurance in this State. Carrier includes an insurance company, health service corporation, managed care organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. Carrier also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health insurance.

“Certificate of Authority” means the authorization by the Department to operate the MCO. This certificate shall be deemed to be a license to operate such an organization.

“Chief Executive Officer” means the individual employed to manage and direct the activities of the MCO.

“Covered health services” means services that are included in the enrollee’s health care contract with the carrier.

“Covered Person”: see “Enrollee.”

“Department” means the Delaware Department of Insurance.

“Emergency care” means health care items or services furnished or required to evaluate or treat an emergency medical condition.

“Emergency medical condition” means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the health of the individual afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;

B. Serious impairment to bodily functions;

C. Serious impairment or dysfunction of any bodily organ or part; or

D. Serious disfigurement of such person.

“Enrollee” means an individual and/or family who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into with the MCO, under which the MCO assumes the responsibility to provide to such person(s) coverage for basic health services and such supplemental health services as are enumerated in the health care contract.

“Geographically accessible” means a location no greater than 30 miles or 40 minutes driving time from 90% of enrollees within MCO’s geographic service area.

“Geographic service area” means the stated primary geographical area served by an MCO. The primary area served shall be a radius of not more than 20 miles or more than 30 minutes driving time from a primary care office operated or contracted by the MCO.

“Grievance” means a request by an enrollee that an MCO review an adverse determination by means of the MCO’s internal review process.

“Health care contract” means any agreement between an MCO and an enrollee or group plan which sets forth the services to be supplied to the enrollee in exchange for payments made by the enrollee or group plan.

“Health care professional” means an individual engaged in the delivery of health care services as licensed or certified by the State of Delaware.

“Health care services” means any services included in the furnishing to any individual of medical or dental care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury or physical disability.

“Independent Health Care Appeals Program” means a program administered by the Department which provides for a review by an Independent Utilization Review Organization.

“Independent Utilization Review Organization (IURO)” means an entity that conducts independent external reviews of a carrier’s determinations resulting in a denial, termination, or other limitation of covered health care services based on medical necessity or appropriateness of services.

“Intermediary” means a person authorized to negotiate and execute provider contracts with MCOs on behalf of health care providers or on behalf of a network.

“Internal review process” means a procedure established by an MCO for internal review of an adverse determination.

“Level 1 trauma center” means a regional resource trauma center that has the capability of providing leadership and comprehensive, definitive care for every aspect of injury from prevention through rehabilitation.

“Level 2 trauma center” means a regional trauma center with the capability to provide initial care for all trauma patients. Most patients would continue to be cared for in this center; there may be some complex cases which would require transfer for the depth of services of a regional Level 1 or specialty center.

“Managed Care Organization (MCO)” means a public or private organization, organized under the laws of any state, which:

A. Provides or otherwise makes available to enrollees health care services, including at least the basic health services defined in this section;

B. Is primarily compensated (except for co-payment) for the provision of basic health services to enrollee on a predetermined periodic rate basis; and

C. Provides physician services.

An MCO may also arrange for health care services on a prepayment or other financial basis.

PROPOSED REGULATIONS

“Medical necessity” means providing of covered health services or products that a prudent physician would provide to a patient for the purpose of diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:

- A. In accordance with generally accepted standards of medical practice;
- B. Consistent with the symptoms or treatment of the condition; and
- C. Not solely for anyone’s convenience.

“Network” means the participating providers delivering services to enrollees.

“Office” means any facility where enrollees receive primary care or other health care services.

“Out of area coverage” means health care services provided outside the MCO’s geographic service areas with appropriate limitations and guidelines acceptable to the Department. At a minimum, such coverage must include emergency care.

“Participating provider” means a provider who, under a contract with the MCO or with its contractor or sub contractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the MCO.

“Premium” means payment(s) called for in the health care contract which must be:

- A. Paid or arranged for by, or on behalf of, the enrollee before health care services are rendered by the MCO;
- B. Paid on a periodic basis without regard to the date on which health care services are rendered; and
- C. With respect to an individual enrollee, are fixed without regard to frequency, extent or cost of health services actually furnished.

“Primary care physician (PCP)” means a participating physician chosen by the enrollee and designated by the MCO to supervise, coordinate, or provide initial care or continuing care to an enrollee, and who may be required by the MCO to initiate a referral for specialty care and maintain supervision of health care services rendered to the enrollee.

“Provider” means a health care professional or facility.

“Staff Model MCO” means an MCO in which physicians are employed directly by the MCO or in which the MCO directly operates facilities which provide health care services to enrollees.

“Tertiary services” means health care services provided for the intensive treatment of critically ill patients who require extraordinary care on a concentrated basis in special diagnostic categories (e.g., burns, cardiovascular, neonatal, pediatric, oncology, transplants, etc.).

“Utilization review” means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, efficacy, and/or efficiency of, health care services, procedures or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

3.0 Certificate of Authority

3.1 Each application for a Certificate of Authority as a Managed Care Organization shall be made on Form No. H-1 entitled "Application for Certificate of Authority as a Managed Care Organization" (Exhibit A to this regulation). The application shall be accompanied by the following:

3.1.1 The information specified in 18 Del.C. §6404(a);

3.1.2 Evidence of accreditation by a nationally-recognized managed care accrediting organization such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or similar organization;

3.1.3 For Staff Model MCOs, evidence that the MCO satisfies the physical plant requirements of a hospital as specified by the Delaware Department of Health and Social Services;

3.1.4 Copies of management, agency or administrative contracts;

3.1.5 Equifax Reports on Officers/Directors; and/or NAIC biographical or other similar biographical forms, as directed by the Department;

3.1.6 Proof of \$50,000 bond for each officer, director, partner, or other individual who receives, collects or invests money;

3.1.7 “Admittance Questionnaire for Certificate of Authority for Managed Care Organization,” Form No. H-2 (Exhibit B to this regulation);

3.1.8 “Designation of official authorized to appoint and remove agents,” Form No. H-3 (Exhibit C

to this regulation);

3.1.9 "Designation of person to receive bulletins, regulations, etc.," Form No. H-4 (Exhibit D to

this regulation);

3.1.10 "Designation of person to receive service of process," Form No. H-5 (Exhibit E to this

regulation);

3.1.11 "Biographical Affidavit of Officers and Directors" (Exhibit F to this regulation); and

3.1.12 "Power of Attorney Form" (Exhibit G to this regulation).

3.2 Each application for a Certificate of Authority as a Managed Care Organization shall be accompanied by a \$750 filing fee in accordance with 18 Del.C. §6409.

3.3 Each application for a Certificate of Authority as a Managed Care Organization shall be accompanied by a deposit of \$100,000 in accordance with 18 Del.C. §513(f).

3.4 All of the items and information specified in the foregoing sections 3.1 through 3.3 must be submitted in order for the Department to review an application for a Certificate of Authority.

3.5 Denial of Application for Certificate of Authority

3.5.1 If, within 60 days after a complete application for a Certificate of Authority has been filed, the Department has not issued such certificate, the Department shall immediately notify the applicant, in writing, of the reasons why such certificate has not been issued, and the applicant shall be entitled to request a hearing on the application.

3.5.2 The hearing shall be held within 60 days of the Department's receipt of the applicant's written request therefor. Proceedings in regard to such hearing shall be conducted in accordance with provisions for case decisions as set forth in the Administrative Procedures Act, Chapter 101 of Title 29, and in accordance with applicable rules and regulations of the Department.

4.0 Capital Funds Required

4.1 Each MCO that obtains a Certificate of Authority shall have and maintain unimpaired capital stock or unimpaired basic surplus of at least \$300,000 and free surplus of at least \$150,000 or the minimum capital and free surplus as may be required by legislative changes adopted by the General Assembly from time to time. These capital and surplus requirements are in addition to the deposit requirements of 18 Del.C. §513(f).

4.2 Each MCO that obtains a Certificate of Authority shall demonstrate that it has provider contracts which require that the provider agrees in the event of non-payment by the MCO that the provider will not seek compensation or have any recourse against an enrollee, as described in section 7.0 of this regulation. In the event that the MCO has not entered into such agreements with all providers, the MCO must demonstrate to the Department's satisfaction that it has made a good faith effort to enter into these agreements. In lieu of these executed provider agreements, the Department, at its discretion, may allow the MCO to engage in the business of a managed care organization if the MCO establishes reserves equal to 25% of the total projected annual incurred claims or benefits payments attributable to the provider which or who has not agreed to enter into a provider agreement.

4.3 Annually, at the time of filing the annual report on June 1, each MCO which has a current Certificate of Authority shall demonstrate that it is in compliance with the requirements of Sections 4.1 and 4.2 of this regulation.

5.0 Reinsurance Requirement

5.1 Each MCO shall secure insurance reinsurance protection to provide to the MCO in the event of catastrophic or unusual losses which would be in excess of the levels of loss which the MCO assumes in the basis of its calculation of premium charges.

6.0 Special Requirement in the Event of Financial Impairment/Insolvency

6.1 In the event of the financial impairment or insolvency of an MCO doing business in this State, each MCO doing business in this State shall permit a 60-day "open enrollment" period for existing enrollees of the impaired/insolvent MCO to enroll in a solvent MCO.

6.2 Each such solvent licensed MCO shall be required to accept within the "open enrollment" period any enrollee who wishes to enroll at the rates or costs and benefits which are then in effect at the chosen MCO for the class or grouping represented by the enrollee.

6.3 Each such solvent licensed MCO shall accept such enrollee without any waiting periods or pre-

existing conditions exclusions and such acceptance both as to premium as well as delivery of service shall be retroactive to the date on which a court of competent jurisdiction has declared the predecessor MCO financially impaired.

7.0 Required Contractual Provisions

7.1 Every contract between an MCO and a participating provider shall contain the following language:

7.1.1 "Provider agrees that in no event, including but not limited to nonpayment by the MCO or intermediary, insolvency of the MCO or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or a person (other than the MCO or intermediary) acting on behalf of the enrollee for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to enrollees."

7.1.2 "In the event of an MCO or intermediary insolvency or other cessation of operations, covered services to enrollees will continue through the period for which a premium has been paid to the MCO on behalf of the enrollee or until the enrollee's discharge from an inpatient facility, whichever time is greater. Covered benefits to enrollees confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary."

7.2 The contract provisions that satisfy the requirements of Section 7.1 above shall be construed in favor of the enrollee, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the MCO, and shall supersede any oral or written contrary agreement between a participating provider and an enrollee or the representative of an enrollee if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Section 7.1 above.

7.3 A contract between an MCO and a participating provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in this regulation.

8.0 Enrollee Rights and Responsibilities

8.1 The MCO shall establish and implement written policies and procedures regarding the rights of enrollees and the implementation of these rights.

8.2 The MCO shall disclose to each new enrollee, and any enrollee upon request, in a format and language understandable to a layperson, the following minimum information:

8.2.1 Benefits covered and exclusions or limitations, including restrictions related to preexisting conditions:

8.2.2 Out-of-pocket costs to the enrollee:

8.2.3 Lists of participating providers:

8.2.4 Policies on the use of primary care physicians, referrals, use of out of network providers, and out of area services:

8.2.5 Policies governing the provision of emergency and urgent care:

8.2.6 Written explanation of the internal and external review processes:

8.2.7 For staff model MCOs, the location and hours of its inpatient and outpatient health services:

8.2.8 A statement of enrollee's rights that includes at least the right:

8.2.8.1 To available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week for urgent or emergency conditions:

8.2.8.2 To be treated with courtesy and consideration, and with respect for the enrollee's dignity and need for privacy:

8.2.8.3 To be provided with information concerning the MCO's policies and procedures regarding products, services, providers, grievance procedures and other information about the organization and the care provided:

8.2.8.4 To choose a primary care provider within the limits of the covered benefits and plan network, including the right to refuse care of specific practitioners:

8.2.8.5 To receive from the enrollee's physician(s) or provider, in terms that the enrollee understands, an explanation of his complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives. If the enrollee is not capable of understanding the

information, the explanation shall be provided to his next of kin or guardian and documented in the enrollee's medical record;

8.2.8.6 To formulate advance directives;

8.2.8.7 To all the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the enrollee understands;

8.2.8.8 To prompt notification of termination or changes in benefits, services or provider network;

8.2.8.9 To file a grievance with the MCO and to receive a response to the grievance within a reasonable period of time; and

8.2.8.10 To file a petition for arbitration or appeal for review by an Independent Utilization Review Organization, as appropriate.

8.2.9 A complete statement of responsibilities of enrollees.

8.3 In the case of nonpayment by the MCO to a participating provider for a covered service in accordance with the enrollee's health care contract, the provider may not bill the enrollee. This does not prohibit the provider from collecting coinsurance, deductibles or co-payments as determined by the MCO. This does not prohibit the provider and enrollee from agreeing to continue services solely at the expense of the enrollee, as long as the provider clearly informs the enrollee that the MCO will not cover these services.

9.0 Provider Relations

9.1 An MCO shall establish a mechanism by which participating providers will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.

9.2 An MCO shall establish procedures for resolution of administrative, payment or other disputes between providers and the MCO.

9.3 The MCO shall establish a policy governing termination of providers. The policy shall include at least:

9.3.1 Written notification to each enrollee six weeks prior to the termination or withdrawal from the MCO's provider network of an enrollee's primary care physician except in cases where termination was due to unsafe health care practices; and

9.3.2 Except in cases where termination was due to unsafe health care practices that compromise the health or safety of enrollees, assurance of continued coverage of services at the contract price by a terminated provider for up to 120 calendar days after notification of termination in cases where it is medically necessary for the enrollee to continue treatment with the terminated provider. In cases of the pregnancy of an enrollee, medical necessity shall be deemed to have been demonstrated and coverage shall continue to completion of postpartum care.

10.0 Prohibited Practices

10.1 An MCO shall not offer incentives to a participating provider to provide less than medically necessary services to an enrollee.

10.2 An MCO shall not penalize a participating provider because the provider, in good faith, reports to State authorities any act or practice by the MCO that jeopardizes patient health or welfare.

10.3 An MCO shall not engage in any other practices prohibited by applicable provisions of Title 18 of the Delaware Code and regulations promulgated thereunder.

11.0 Quality Assurance and Operations

11.1 Medical Director's Duties. The medical director shall be responsible for the direction, provision and quality of health care services provided to enrollees, including but not limited to the following:

11.1.1 Establishing policies and procedures covering all health care services provided to enrollees;

11.1.2 Coordinating, supervising and overseeing the functioning of professional services;

11.1.3 Providing clinical direction and leadership to the continuous quality improvement and utilization management programs;

11.1.4 Providing clinical direction to physicians responsible for utilization management

PROPOSED REGULATIONS

determinations:

11.1.5 Establishing a committee responsible for delineating qualifications of participating providers and reviewing and verifying credentials of participating providers:

11.1.6 Evaluating the medical aspects of provider contracts; and

11.1.7 Overseeing the continuing in-service education of professional staff.

11.2 Health Care Professional Credentialing

11.2.1 General Responsibilities. An MCO shall:

11.2.1.1 Establish written policies and procedures for credentialing verification of all health care professionals with whom the MCO contracts and apply these standards consistently:

11.2.1.2 Verify the credentials of a health care professional before entering into a contract with that health care professional:

11.2.1.3 Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures:

11.2.1.4 Retain all records and documents relating to a health care professional's credentialing verification process for not less than four years; and

11.2.1.5 Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

11.2.2 Selection standards for participating providers shall be developed for primary care professionals and each health care professional discipline. The standards shall be used in determining the selection of health care professionals by the MCO, its intermediaries and any provider networks with which it contracts. Selection criteria shall not be established in a manner:

11.2.2.1 That would allow an MCO to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization; or

11.2.2.2 That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization.

11.2.3 Nothing in these regulations shall be construed to require an MCO to select a provider as a participating provider solely because the provider meets the MCO's credentialing verification standards, or to prevent the MCO from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

11.2.4 Verification Responsibilities. An MCO shall:

11.2.4.1 Obtain primary verification of at least the following information about the applicant:

11.2.4.1.1 current license, certification, or registration to render health care in Delaware and history of same;

11.2.4.1.2 current level of professional liability coverage, if applicable;

11.2.4.1.3 status of hospital privileges, if applicable;

11.2.4.1.4 specialty board certification status, if applicable; and

11.2.4.1.5 current Drug Enforcement Agency (DEA) registration certificate, if applicable.

11.2.4.2 Obtain, subject to either primary or secondary verification:

11.2.4.2.1 the health care professional's record from the National Practitioner Data Bank; and

11.2.4.2.2 the health care professional's malpractice history.

11.2.4.3 Not less than every three years obtain primary verification of a participating health care professional's:

11.2.4.3.1 current license or certification to render health care in Delaware;

11.2.4.3.2 current level of professional liability coverage, if applicable;

11.2.4.3.3 status of hospital privileges, if applicable;

11.2.4.3.4 current DEA registration certificate, if applicable; and

11.2.4.3.5 specialty board certification status, if applicable.

11.2.4.4 Require all participating providers to notify the MCO of changes in the status of any of the items listed in this section 11.2.4 at any time and identify for participating providers the individual to whom they should report changes in the status of an item listed in this section 11.2.4.

11.2.5 Health Care Professional's Right to Review Credentialing Verification Information. An MCO shall provide a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification application.

11.3 Provider Network Adequacy

11.3.1 Primary, Specialty and Ancillary Providers

11.3.1.1 The MCO shall maintain an adequate network of primary care providers, specialists, and other ancillary health care resources to serve enrollees at all times.

11.3.1.2 If a plan has an insufficient number of providers that are geographically accessible and available within a reasonable period of time to provide covered health services to enrollees, the MCO shall cover non-network providers, and shall prohibit balance billing.

11.3.1.3 The MCO shall allow referral to a non-network provider, upon the request of a network provider, when medically necessary covered health services are not available through network providers, or the network providers are not available within a reasonable period of time. The MCO shall make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing.

11.3.2 Facility and Ancillary Health Care Services

11.3.2.1 The MCO shall maintain contracts or other arrangements acceptable to the Department with institutional providers which have the capability to provide covered health services to enrollees and are geographically accessible.

11.3.2.2 The MCO shall make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing, if the appropriate level of service is not geographically accessible. These services will not be limited to the State of Delaware. These services could include but are not limited to tertiary services, burn units and transplant services.

11.3.3 Emergency and Urgent Care Services

11.3.3.1 The MCO shall establish written policies and procedures governing the provision of emergency and urgent care which shall be distributed to each enrollee at the time of initial enrollment and after any revisions are made. These policies shall be easily understood by a layperson.

11.3.3.2 When emergency care services are performed by non-network providers, the MCO shall make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing. In those cases where the MCO and the provider cannot agree upon the appropriate charge, the provider may petition the Department for arbitration.

11.3.3.3 Enrollees shall have access to emergency care 24 hours per day, seven days per week. The MCO shall cover emergency care necessary to screen and stabilize an enrollee and shall not require prior authorization of such services if a prudent lay person acting reasonably would have believed that an emergency medical condition existed.

11.3.3.4 Emergency and urgent care services shall include but are not limited to:

11.3.3.4.1 medical and psychiatric care, which shall be available 24 hours a day, seven days a week;

11.3.3.4.2 trauma services at any designated Level I or II trauma center as medically necessary. Such coverage shall continue at least until the enrollee is medically stable, no longer requires critical care, and can be safely transferred to another facility, in the judgment of the treating physician. If the MCO requests transfer to a hospital participating in the MCO network, the patient must be stabilized and the transfer effected in accordance with federal regulations at 42 CFR 489.20 and 42 CFR 489.24;

11.3.3.4.3 out of area health care for urgent or emergency conditions where the enrollee cannot reasonably access in-network services;

11.3.3.4.4 hospital services for emergency care; and

11.3.3.4.5 upon arrival in a hospital, a medical screening examination, as required under federal law, as necessary to determine whether an emergency medical condition exists.

11.3.3.5 When an enrollee has received emergency care from a non-network provider and is stabilized, the enrollee or the provider must request approval from the MCO for continued post-stabilization care by a non-network provider. The MCO is required to approve or disapprove coverage of post-stabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of services and the condition of the enrollee, but in no case to exceed one hour from the time of the request.

11.3.4 The MCO shall submit evidence of network adequacy to the Department upon request. If

PROPOSED REGULATIONS

the Department receives a complaint regarding an MCO's network adequacy, the burden shall be on the MCO to prove network adequacy to the satisfaction of the Department.

11.4 Utilization Management

11.4.1 The MCO shall establish and implement a comprehensive utilization management program to monitor access to and appropriate utilization of health care and services. The program shall be under the direction of a designated physician and shall be based on a written plan that is reviewed at least annually.

11.4.2 Utilization management determinations shall be based on written clinical criteria and protocols reviewed and approved by practicing physicians and other licensed health care providers within the network. These criteria and protocols shall be periodically reviewed and updated, and shall, with the exception of internal or proprietary quantitative thresholds for utilization management, be readily available, upon request, to affected providers and enrollees.

11.4.3 All materials including internal or proprietary materials for utilization management shall be available to the Department upon request.

11.4.4 Compensation to persons providing utilization review services for an MCO shall not contain incentives, direct or indirect, for these persons to make inappropriate review decisions. Compensation to any such persons may not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

11.4.5 Utilization Management Staff Availability

11.4.5.1 At a minimum, appropriately qualified staff shall be immediately available by telephone, during routine provider work hours, to render utilization management determinations for providers.

11.4.5.2 The MCO shall provide enrollees with a toll free telephone number by which to contact customer service staff on at least a five day, 40 hours a week basis.

11.4.5.3 The MCO shall supply providers with a toll free telephone number by which to contact utilization management staff on at least a five day, 40 hours a week basis.

11.4.5.4 The MCO must have policies and procedures addressing response to inquiries concerning emergency or urgent care when a PCP or his authorized on call back up provider is unavailable.

11.4.6 Utilization Management Determinations

11.4.6.1 All determinations to authorize services shall be rendered by appropriately qualified staff.

11.4.6.2 All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician. The physician shall be under the clinical direction of the medical director responsible for medical services provided to the MCO's Delaware enrollees. Such determinations shall be made in accordance with clinical and medical criteria and standards and shall take into account the individualized needs of the enrollee for whom the service, admission, procedure or extension is requested.

11.4.6.3 All determinations shall be made on a timely basis as required by the exigencies of the situation.

11.4.6.4 An MCO may not retroactively deny reimbursement for a covered health service provided to an enrollee by a provider who relied upon the written or verbal authorization of the MCO or its agents prior to providing the service to the enrollee, except in cases where the MCO can show that there was material misrepresentation, fraud or the patient was found not to have coverage.

11.4.6.5 An enrollee must receive written notice of all determinations to deny coverage or authorization for services required and the basis for the denial.

11.5 Quality Assessment and Improvement

11.5.1 Continuous Quality Improvement

11.5.1.1 Under the direction of the Medical Director or his designated physician, the MCO shall have a system-wide continuous quality improvement program to monitor the quality and appropriateness of care and services provided to enrollees. This program shall be based on a written plan which is reviewed at least semi-annually and revised as necessary.

11.5.1.2 The MCO shall assure that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system.

11.5.1.3 The MCO shall provide enrollees the opportunity to comment on the quality improvement process.

11.5.1.4 The MCO shall follow up on findings from the program to assure that

effective corrective actions have been taken, including at least policy revisions, procedural changes and implementation of educational activities for enrollees and providers.

11.5.1.5 The MCO shall make documentation regarding the quality improvement program available to the Department upon request.

11.5.2 External Quality Audit

11.5.2.1 Each MCO shall submit, as a part of its annual report due June 1, evidence of its most recent external quality audit that has been conducted or of acceptable accreditation status.

11.5.2.2 The report of the external quality audit must describe in detail the MCO's conformance to performance standards and the rules within this regulation. The report shall also describe in detail any corrective actions proposed and/or undertaken by the MCO.

11.5.2.3 External quality audits must be completed no less frequently than once every three years. Such audit shall be performed by a nationally known accreditation organization or an independent quality review organization acceptable to the Department.

11.5.2.4 In lieu of the external quality audit, the Department may accept evidence that an MCO has received and has maintained the appropriate accreditation from a nationally known accreditation organization or independent quality review organization.

11.5.3 Reporting and Disclosure Requirements

11.5.3.1 An MCO shall document and communicate information about its quality assessment program and its quality improvement program, and shall:

11.5.3.1.1 include a summary of its quality assessment and quality improvement programs in marketing materials;

11.5.3.1.2 include a description of its quality assessment and quality improvement programs and a statement of enrollee rights and responsibilities with respect to those programs in the materials or handbook provided to enrollees; and

11.5.3.1.3 make available annually to participating providers and enrollees findings from its quality assessment and quality improvement programs and information about its progress in meeting internal goals and external standards, where available. The reports shall include a description of the methods used to assess each specific area and an explanation of how any assumptions affect the findings.

11.5.3.2 An MCO shall submit to the Department such performance and outcome data as the Department may request.

12.0 Recordkeeping and Reporting Requirements

12.1 Medical Records Retention

12.1.1 The MCO must maintain or provide for the maintenance of a medical records system which meets the accepted standards of the health care industry and State and federal regulations.

12.1.1.1 The MCO shall provide sufficient space and equipment for the processing and the safe storage of records.

12.1.1.2 Medical records shall be protected from loss, damage and unauthorized use.

12.1.2 Retention and Destruction

12.1.2.1 With the exception of medical records of minors (individuals under the age of 18 years), medical records shall be preserved as original records, on microfilm or electronically stored for no less than five years after the most recent patient care usage, after which time records may be destroyed at the discretion of the MCO.

12.1.2.2 Medical records of minors shall be preserved for the period of minority plus five years (i.e., 23 years) or as otherwise required by State law.

12.1.2.3 An MCO shall establish procedures for notification to patients whose records are to be destroyed prior to the destruction of such records.

12.1.3 The Department shall have access to medical records for purposes of monitoring and review of MCO practices.

12.2 Reporting Requirements and Statistics

12.2.1 Annual reports. In addition to the information required to be included in an MCO's annual report as specified in 18 Del.C. §6406 or elsewhere in this regulation, an MCO shall submit the following information to the Department on an annual basis:

PROPOSED REGULATIONS

- 12.2.1.1 A statistical summary evaluating the network adequacy and accessibility to the enrolled population;
- 12.2.1.2 Annual appeal report of all grievances, petitions for arbitration and appeals under the Independent Health Care Appeals Program as required under Department Regulation 1301.
- 12.2.1.3 Evidence of compliance with the capital funds requirements of section 4.0 of this regulation.
- 12.2.2 An MCO shall submit the following information to the Department whenever there is a change:
- 12.2.2.1 Substantial changes in organization, bylaws, or governing board
- 12.2.2.2 Full name of the Chief Executive Officer
- 12.2.2.3 Full name of the Medical Director
- 12.2.2.4 Substantial changes in marketing materials, grievance procedures or the utilization management program
- 12.2.2.5 Any significant amendment to or revision relating to the text or subtext of an approved provider contract shall be submitted to and approved by the Department prior to the execution of an amended or revised contract with the providers of an MCO.

13.0 Compliance with Regulation

13.1 The MCO is responsible for meeting each requirement of this regulation. If the MCO chooses to utilize contract support or to contract functions under this regulation, the MCO retains responsibility for ensuring that the requirements of this regulation are met.

13.2 The Department may require a corrective action plan from an MCO when the Department determines that the MCO is not in compliance with applicable provisions of Title 18 of the **Delaware Code** or regulations promulgated thereunder.

14.0 Separability Provisions

14.1 If any provision of this regulation shall be held invalid, the remainder of the regulation shall not be affected thereby.

DEPARTMENT OF NATURAL RESOURCES AND ENVIRONMENTAL CONTROL

DIVISION OF AIR AND WASTE MANAGEMENT

Statutory Authority: 7 Delaware Code, Chapter 60 (7 **Del.C.**, Ch. 60)

PUBLIC NOTICE

1. Title of the Regulations:

Delaware Regulation Governing the Control of Air Pollution No. 1142 Section 2: Control of NOx Emissions from Industrial Boilers and Process Heaters at Petroleum Refineries.

2. Brief Synopsis of the Subject, Substance and Issues:

The Clean Air Act Amendments of 1990 (CAA) requires Delaware, as part of the Philadelphia-Wilmington-Atlanta City non-attainment area, to attain the 8-hour ozone National Ambient Air Quality Standard (NAAQS) by 2010. Since oxides of nitrogen (NOx) is one of the two major precursors that form ozone in the lower atmosphere, Delaware must reduce NOx emissions in order to reduce ambient ozone concentrations, to attain the NAAQS. According to the requirements of US Environmental Protection Agency (EPA), NOx reductions must be achieved by May of 2009 to ensure attainment by 2010. Delaware's emission inventory data demonstrates that large industrial boilers and process heaters in petroleum refineries in Delaware are significant NOx emitting sources. Therefore, those large boilers and process heaters should be subject to appropriate NOx emission controls.

The proposed Regulation 1142 Section 2 will affect large refinery boilers and process heaters with heat input capacities equal to or greater than 200 million British thermal units per hour (mmBTU/hour). By setting up

appropriate emission rate limits and control implementation schedules for those units, NO_x emission reductions will be achieved in 2009 to help Delaware attain the ozone NAAQS, and additional reduction will be achieved in 2011-2012 period to help Delaware to maintain the ozone standard once it is attained.

The proposed regulation and the associated NO_x emission reductions will be included in Delaware State Implementation Plan (SIP) revisions to demonstrate Delaware's capability to make reasonable progress towards attainment, to attain the ozone standard in 2010, and to maintain the ozone standard thereafter. Those SIP revisions are due to EPA by June 2007.

In addition to aiding the adequate progress toward, and ultimate attainment of the ozone NAAQS, the proposed regulation will aid Delaware in attaining the fine particulate matter (PM) NAAQS by 2010, help satisfy Delaware's compliance with the federal Clean Air Interstate Rule (CAIR) and the federal Nitrogen Oxides Transport State Implementation Plan (SIP) Call, help satisfy EPA's finding that Delaware failed to submit a Clean Air Act Section 110 SIP addressing upwind interstate transport for the ozone and fine particulate matter NAAQS, and improve visibility.

3. Possible Terms of the Agency Action:

None.

4. Statutory Basis or Legal Authority to Act:

7 Del.C., Chapter 60, Environmental Control

5. Other Regulations That May Be Affected by the Proposal:

None

6. Notice of Public Comment:

A public hearing will be held on March 6, 2007, beginning at 6:00 pm, in DNREC Conference Room A, 391 Lukens Drive, New Castle, DE 19720.

7. Prepared By:

Frank F. Gao, Project Leader Phone: (302) 323-4542

Date: January 11, 2007

E-Mail: Frank.Gao@state.de.us

1142 Specific Emission Control Requirements

xx/xx/200x

1.0 Control of NO_x Emissions from Industrial Boilers

1.1 Purpose.

New Castle County and Kent County are part of the Philadelphia-Wilmington-Trenton 1-hour ozone non-attainment area. All areas of Delaware impact this non-attainment area. On December 19, 1999 the EPA identified an emission reduction "shortfall" associated with this non-attainment area. Promulgation of Section 1 of this regulation is one measure that the Department is taking to mitigate this shortfall.

In determining the applicability of this Section the Department attempted to minimize the impact on facilities that recently installed NO_x controls under Regulation No. 12 (NO_x RACT) and Regulation No. 37/39 (NO_x Budget Trading Program). The Department did this by regulating only large sources that, as of the effective date of this Section, emitted NO_x at a rate greater than the rate identified in Table I of Regulation No. 12, were not equipped with NO_x emission control technology, and were not subject to the requirements of Regulation No. 39. In effect, this Section regulates sources that remain high NO_x emitters after the application of RACT and post RACT requirements, and that have not committed substantial capital funds to reduce NO_x emissions.

1.2 Applicability.

1.2.1 This section applies to any person that owns or operates any combustion unit with a maximum heat input capacity of equal to or greater than 100 million btu per hour, except that this section shall not apply to any unit that, as of the effective date of this Section:

1.2.1.1 Emits NO_x at a rate equal to or less than the rate identified in Table I of Regulation No. 12 of the State of Delaware "Regulations Governing the Control of Air Pollution."

1.2.1.2 Is equipped with low NO_x burner, flue gas recirculation, selective catalytic reduction, or selective noncatalytic reduction technology.

1.2.1.3 Is subject to the requirements of Regulation No. 39 of the State of Delaware "Regulations Governing the Control of Air Pollution."

1.2.2 The requirements of this section are in addition to all other state and federal requirements.

1.2.3 Affected persons shall comply with the requirements of paragraph 1.3 of this Section as soon as practicable, but no later than May 1, 2004.

1.3 Standards.

1.3.1 The NO_x emission rate from any unit subject to this Section shall be equal to or less than the following:

1.3.1.1 Between May 1st through September 30th of each year, inclusive: 0.10 lb/mmBTU, 24-hour calendar day average.

1.3.1.2 During all times that gaseous fuel is being fired: 0.10 lb/mmBTU, 24-hour calendar day average.

1.3.1.3 During all times not covered by Section 1.3.1.1 and 1.3.1.2: 0.25 lb/mmBTU, 24-hour calendar day average.

1.3.2 As an alternative to compliance with the requirements of paragraph 1.3.1 of this Section, compliance may be achieved through the procurement and retirement of NO_x allowances authorized for use under Regulation No. 39 of the State of Delaware "Regulations Governing the Control of Air Pollution," as follows:

1.3.2.1 The actual 24-hour calendar day average NO_x emission rate in pounds per million btu shall be determined for each day of unit operation, using CEMs operated in accordance with paragraph 1.4 of this section.

1.3.2.2 The actual heat input to each unit in million btu shall be determined for each day of unit operation, using methods proposed by the person subject to this Section and acceptable to the Department.

1.3.2.3 0.10 or 0.25, as applicable and consistent with paragraph 1.3.1 of this section, shall be subtracted from the rate determined in paragraph 1.3.2.1 of this section.

1.3.2.4 To obtain the number of pounds of NO_x emitted for a particular day the emission rate determined in paragraph 1.3.2.3 of this section shall be multiplied by the heat input to the unit for that day determined in paragraph 1.3.2.2 of this section. If the emission rate determined in paragraph 1.3.2.3 of this section is equal to or less than zero, then the number of pounds of NO_x emitted for that day shall be zero.

1.3.2.5 Not later than the 20th day of each month:

1.3.2.5.1 The number of pounds of NO_x emissions calculated pursuant to paragraph 1.3.2.4 of this section shall be summed for each calendar month, the result shall be divided by 2000, and shall be rounded to the nearest whole ton.

1.3.2.5.2 For each ton of NO_x emissions calculated pursuant to paragraph 1.3.2.5.1, records shall be maintained demonstrating that one NO_x allowance owned by the person subject to this Section is identified and available, by serial number, for retirement.]

1.3.2.6 Not later than February 1 of each calendar year, the NO_x allowances identified pursuant to paragraph 1.3.2.5.2 of this Section for the previous calendar year, shall be submitted to the Department for retirement. Such submission shall detail the calculations specified in 1.3.2.1 through 1.3.2.5 above, and shall indicate the serial number of each allowance to be retired.

1.4 Monitoring Requirements. Compliance with the NO_x emission standards specified in this section shall be determined based on CEM data collected in accordance with the requirements of Regulation 17, Section 3.1.2 (Performance Specification 2), and in compliance with the requirements of 40 CFR, Part 60, Appendix F.

1.5 Recordkeeping and Reporting Requirements.

1.5.1 Not later than 180 days after the effective date of this Section, any person subject to this Section shall develop, and submit to the Department for approval, a schedule for bringing the affected emission unit(s) into compliance with the requirements of this Section. Such schedule shall include, at a minimum, all of the following:

1.5.1.1 The method by which compliance will be achieved

1.5.1.2 The dates by which the affected person commits to completing the following major increments of progress, as applicable:

1.5.1.2.1 Completion of engineering

1.5.1.2.2 Submission of permit applications

1.5.1.2.3 Awarding of contracts for construction and/or installation

1.5.1.2.4 Initiation of construction

1.5.1.2.5 Completion of construction

1.5.1.2.6 Commencement of trial operation

1.5.1.2.7 Initial compliance testing

1.5.1.2.8 Submission of compliance testing reports

1.5.1.2.9 Commencement of normal operations (in full compliance)

1.5.2 Any person subject to this Section shall submit to the Department an initial compliance certification not later than May 1, 2004. The initial compliance certification shall, at a minimum, include the following information:

1.5.2.1 The name and the location of the facility.

1.5.2.2 The address and telephone number of the person responsible for the facility.

1.5.2.3 Identification of the subject source(s).

1.5.2.4 The applicable standard.

1.5.2.5 The method of compliance.

1.5.2.6 Certification that each subject source is in compliance with the applicable standard

1.5.2.7 All records necessary for determining compliance with the standards of this Section shall be maintained at the facility for a period of five years.

1.5.3 Any person subject to this Section shall, for each occurrence of excess emissions, within 30 calendar days of becoming aware of such occurrence, supply the Department with the following information:

1.5.3.1 The name and location of the facility.

1.5.3.2 The subject source(s) that caused the excess emissions.

1.5.3.3 The time and date of first observation of the excess emissions.

1.5.3.4 The cause and expected duration of the excess emissions.

1.5.3.5 The estimated rate of emissions (expressed in the units of the applicable emission limitation) and the operating data and calculations used in determining the magnitude of the excess emissions.

1.5.3.6 The proposed corrective actions and schedule to correct the conditions causing the excess emissions.

1.5.4 Any person subject to this section shall maintain all information necessary to demonstrate compliance with the requirements of this section for a minimum period of five years. Such information shall be immediately made available to the Department upon verbal and written request.

5 DE Reg. 1299 (12/1/01)

2.0 Control of NOx Emissions from Industrial Boilers and Process Heaters at Petroleum Refineries

2.1 Purpose

The purpose of Section 2.0 of this regulation is to reduce NOx emissions from Delaware's large industrial boilers and process heaters that are located at petroleum refineries.

Under the 8-hour ozone national ambient air quality standard (NAAQS), the state of Delaware is part of the Philadelphia-Wilmington-Atlantic City, PA-DE-MD-NJ moderate non-attainment area (NAA). The entire NAA, including Delaware, is required by the Clean Air Act (CAA) to attain the 8-hour ozone NAAQS by 2010. After attainment, the area must maintain compliance with the NAAQS. By implementing Section 2.0 of this regulation, NOx emission reductions from the affected boilers and heaters shall contribute to (1) attainment and maintenance of the 8-hour ozone standard, and (2) improvement of the ambient air quality, in both Delaware and the entire NAA.

Additionally, New Castle County of Delaware is a part of the Philadelphia-Wilmington-Camden, PA-DE-NJ NAA for the annual fine particulate matter (PM2.5) NAAQS, and is required by the CAA to attain the NAAQS by 2010. Since NOx is a significant precursor to PM2.5 formation, reducing NOx emissions will also assist

PROPOSED REGULATIONS

in attainment and maintenance of the PM_{2.5} standard.

2.2 Applicability and Compliance Dates

2.2.1 Section 2.0 of this regulation applies to any industrial boiler or process heater with a maximum heat input capacity of equal to or greater than 200 million BTUs per hour (mmBTU/Hour) (except for any Fluid Catalytic Cracking Unit carbon monoxide (CO) boiler), which is operated or permitted to operate within a petroleum refinery facility on the effective date of this section. This comprises the following nine (9) units at the Delaware City refinery:

- 2.2.1.1 Crude Unit Vacuum Heater (Unit 21-H-2)
- 2.2.1.2 Crude Unit Atmospheric Heater (Unit 21-H-701)
- 2.2.1.3 Fluid Coking Unit Carbon Monoxide boiler (Unit 22-H-3)
- 2.2.1.4 Steam Methane Reformer Heater (Unit 37-H-1)
- 2.2.1.5 Continuous Catalyst Regenerator Reformer Heater (Unit 42-H-1,2,3)
- 2.2.1.6 Boiler 1 (Unit 80-1)
- 2.2.1.7 Boiler 2 (Unit 80-2)
- 2.2.1.8 Boiler 3 (Unit 80-3)
- 2.2.1.9 Boiler 4 (Unit 80-4)

2.2.2 The requirements of Section 2.0 of this regulation are in addition to all other state and federal requirements.

2.2.3 The following units shall be in compliance with the requirements of Section 2.0 of this regulation on and after (insert the effective date of this regulation): Crude Unit Atmospheric Heater (Unit 21-H-701), Steam Methane Reformer Heater (Unit 37-H-1) and Boiler 2 (Unit 80-2).

2.2.4 The following units shall be in compliance with the requirements of Section 2.0 of this regulation as soon as practicable, but not later than:

- 2.2.4.1 December 31, 2008: Boiler 1 (Unit 80-1) and Crude Unit vacuum Heater (Unit 21-H-2).
- 2.2.4.2 May 1, 2011: Boiler 3 (Unit 80-3) and Boiler 4 (Unit 80-4).
- 2.2.4.3 December 31, 2012: Continuous Catalyst Regenerator Reformer Heater (Unit 42-H-1, 2, 3).

2.3 Standards.

The owner or operator of any industrial boiler or process heater identified in Section 2.2.1 of this regulation shall not allow NO_x to be emitted at a rate that exceeds the following:

2.3.1 For the Fluid Coking Unit Carbon Monoxide boiler (Unit 22-H-3), Reserved.

2.3.2 For the Steam Methane Reformer (SMR) Heater (Unit 37-H-1), 0.07 lb/mmBTU, on a 24-hour rolling average basis.

2.3.3 Boiler 3 (Unit 80-3) and Boiler 4 (Unit 80-4) shall not operate after May 1, 2011. On or before May 1, 2011 the owner or operator of Boiler 3 and Boiler 4 shall request that any operating permit issued by the Department be cancelled.

2.3.4 For any unit not covered by 2.3.1, 2.3.2, or 2.3.3, 0.04 lb/mmBTU, on a 24-hour rolling average basis.

2.4 Monitoring Requirements. Compliance with the NO_x emission standards specified in 2.3.1, 2.3.2, and 2.3.4 of this regulation shall be determined based on CEM data collected in accordance with the appropriate requirements set forth in 40 CFR, Part 60, Appendix B, Performance Specification 2, and the QA/QC requirements in 40 CFR Part 60, Appendix F.

2.5 Recordkeeping and Reporting Requirements

2.5.1 Not later than 180 days after the effective date of Section 2.0 of this regulation, any person subject to Section 2.0 of this regulation shall develop, and submit to the Department, a schedule for bringing the affected emission unit(s) identified in Section 2.2.4, into compliance with the requirements of Section 2.3 of this regulation. Such schedule shall include, at a minimum, all of the following:

2.5.1.1 The method by which compliance will be achieved.

2.5.1.2 The dates by which the affected person plans to complete the following major increments of progress, as applicable:

- 2.5.1.2.1 Completion of engineering
- 2.5.1.2.2 Submission of permit applications
- 2.5.1.2.3 Awarding of contracts for construction and/or installation

<u>2.5.1.2.4</u>	<u>Initiation of construction</u>
<u>2.5.1.2.5</u>	<u>Completion of construction</u>
<u>2.5.1.2.6</u>	<u>Commencement of trial operation</u>
<u>2.5.1.2.7</u>	<u>Initial compliance testing</u>
<u>2.5.1.2.8</u>	<u>Submission of compliance testing reports</u>
<u>2.5.1.2.9</u>	<u>Commencement of normal operations (in full compliance)</u>

2.5.2 Any person subject to Section 2.0 of this regulation shall submit to the Department an initial compliance certification by (insert 60 days after the effective date of this regulation) for units identified in Section 2.2.3 of this regulation and, for units identified in Section 2.2.4, by the compliance date specified in Section 2.2.4. The initial compliance certification shall include, at a minimum, all of the following information:

2.5.2.1 The name and the location of the facility.
2.5.2.2 The name, address and telephone number of the person responsible for the facility.

2.5.2.3 Identification of the subject source(s).
2.5.2.4 The applicable standard.
2.5.2.5 The method of compliance.
2.5.2.6 Certification that each subject source is in compliance with the applicable standard.

2.5.3 Any person subject to Section 2.0 of this regulation shall, for each occurrence of excess emissions above the standards of Section 2.3 of this regulation, within thirty (30) calendar days of becoming aware of such occurrence, supply the Department with the following information:

2.5.3.1 The name and location of the facility.
2.5.3.2 The subject source(s) that caused the excess emissions.
2.5.3.3 The time and date of first observation of the excess emissions.
2.5.3.4 The cause and expected duration of the excess emissions.
2.5.3.5 The estimated rate of emissions (expressed in the units of the applicable emission limitation) and the operating data and calculations used in determining the magnitude of the excess emissions.

2.5.3.6 The proposed corrective actions and schedule to correct the conditions causing the excess emissions.

2.5.4 Any person subject to Section 2.0 of this regulation shall maintain all information necessary to determine and demonstrate compliance with the requirements of this section for a minimum period of five (5) years. Such information shall be immediately made available to the Department upon verbal and written request.

DIVISION OF FISH AND WILDLIFE

Statutory Authority: 7 Delaware Code, Section 903(e)(2)(a) (7 Del.C. §903(e)(2)(a))
7 DE Admin. Code 3581

PUBLIC NOTICE SAN #2006-20

1. Title of the Regulations:

Amend – Spiny Dogfish; Closure of Fishery

2. Brief Synopsis of the Subject, Substance and Issues:

This action would re-open the spiny dogfish (*Squalus acanthias*) commercial fishery in accordance with the Atlantic States Marine Fisheries Commission's Interstate Management Plan for Spiny Dogfish as amended and in accordance with federal law, whichever is more restrictive. It has been determined that over-fishing of this stock is no longer taking place and that there is significant biomass available for harvest. Other states have re-opened their commercial fisheries for spiny dogfish recently. The State of Delaware is proposing that no vessel may land in

PROPOSED REGULATIONS

Delaware more than 600 pounds per day of spiny dogfish during either of the two federal quota periods; May 1 through October 31, and November 1 through April 30. We are also proposing that if federal limits are more restrictive than Delaware limits, then federal limits apply in Delaware waters for closure periods on the daily take and landing of spiny dogfish per vessel. When federal waters are closed to the taking of spiny dogfish, Delaware's fishery also shall be closed.

3. Possible Terms Of The Agency Action:

N/A

4. Statutory Basis Or Legal Authority To Act:

Chapters 15, and §903(e)(2)(a), and §903(f) of 7 **Delaware Code**.

5. Other Regulations That May Be Affected By The Proposal:

This would amend regulation 3581 Spiny dogfish; Closure of fishery (formerly Tidal Finfish Reg. 27)

6. Notice Of Public Comment:

A Public Hearing is scheduled for February 21, 2007 at 6:30 PM, DNREC auditorium, Dover, DE. Comments for the hearing record should be addressed to Lisa Vest, Hearing Officer, Office of the Secretary, Delaware Department of Natural Resources and Environmental Control, 89 Kings Highway, Dover, DE 19901 or by email to Lisa.Vest@state.de.us.

7. Prepared By:

Roy W. Miller, 739-9914, January 11, 2007
Email address: Roy.Miller@state.de.us

3581 Spiny Dogfish; Closure of Fishery (Formerly Tidal Finfish Reg. 27)
(Penalty Section 7 **Del.C.** §936(b)(2))

1.0 It shall be unlawful for any commercial fisherman to harvest, land or possess any spiny dogfish, *Squalus acanthias*, in Delaware except in those sizes, seasons, and quantities permitted in accordance with the Atlantic States Marine Fisheries Commission Interstate Fishery Management Plan for Spiny Dogfish as amended, or federal law administered by the National Marine Fisheries Service, whichever is more restrictive. It shall be unlawful to commercial harvest, land or possess spiny dogfish during any time when adjoining federal waters are closed to the taking of spiny dogfish. It shall be unlawful for any person to possess the fins from any spiny dogfish prior to landing said spiny dogfish unless said fins are naturally attached to the body of said spiny dogfish. All spiny dogfish landed in Delaware for commercial purposes must be reported through the normal state reporting system.

4 DE Reg. 1859 (5/1/01)

DEPARTMENT OF STATE

DIVISION OF PROFESSIONAL REGULATION

2000 Board of Occupational Therapy

Statutory Authority: 24 Delaware Code, Section 2006(a)(1) (24 **Del.C.** §2006(a)(1))
24 **DE Admin. Code** 2000

PUBLIC NOTICE

The Delaware Board of Occupational Therapy, in accordance with 24 **Del.C.** §2006(a)(1), has proposed changes to its Regulations 2.0 and 3.0 to change the audit process for license renewal so that continuing education attestations will be audited after the license renewal period is over, rather than before the expiration date. The changes will also extend the period of time during each biennial licensure period during which licensees may obtain required CE credits from May 31st of each renewal year to July 31st of each renewal year, to correspond with the

license renewal period.

A public hearing will be held on March 7, 2007 at 4:45 p.m. in the second floor conference room B of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware, where members of the public can offer comments. Anyone wishing to receive a copy of the proposed rules and regulations may obtain a copy from the Delaware Board of Occupational Therapy, 861 Silver Lake Blvd, Cannon Building, Suite 203, Dover DE 19904. Persons wishing to submit written comments may forward these to the Board at the above address. The final date to receive written comments will be at the public hearing.

The Board will consider promulgating the proposed regulations at its regularly scheduled meeting following the public hearing.

2000 Board of Occupational Therapy

(Break in Continuity of Sections)

2.0 Licensure Procedures:

2.1 To apply for an initial license, including relicensure after expiration, an applicant shall submit to the Board:

2.1.1 A completed notarized application on the form approved by the Board;

2.1.2 Verification of a passing score on the NBCOT standardized exam submitted by the exam service or NBCOT;

2.1.2.1 If the date of application for licensure is more than three years following the successful completion of the NBCOT exam, the applicant shall submit proof of twenty (20) hours of continuing education in the two years preceding the application in accordance with Rule 5.0 of these rules and regulations.

2.1.3 Official transcript and proof of successful completion of field work submitted by the school directly to the Board office;

2.1.4 Fee payable to the State of Delaware.

2.2 To apply for a reciprocal license, in addition to the requirements listed in 24 **Del.C.** §2011, an applicant shall submit the following to the Board:

2.2.1 A completed notarized application on the form approved by the Board;

2.2.2 Verification of a passing score on the NBCOT standardized exam submitted by the exam service or NBCOT;

2.2.3 Letter of verification from any state in which the applicant has been licensed (the applicant is responsible for forwarding the blank verification form to all states where they are now or ever have been licensed);

2.2.4 Fee payable to the State of Delaware.

2.3 To apply for renewal, an applicant shall submit:

2.3.1 A completed renewal application on the form approved by the Board. Beginning in 2006, license renewal may be accomplished online at www.dpr.delaware.gov;

~~2.3.2 Proof of meeting continuing education requirements as designated by the Board in Rule 3.0;~~

~~2.3.3~~ 2.3.2 Renewal fee payable to the State of Delaware.

2.4 To apply for inactive status:

A licensee may, upon written request to the Board, have his/her license placed on inactive status if he/she is not actively engaged in the practice of occupational therapy in the State.

2.5 To apply for reactivation of an inactive license, a licensee shall submit:

2.5.1 A letter requesting reactivation;

2.5.2 A completed application for renewal

2.5.3 Proof of continuing education attained within the past two years (20 contact hours). The twenty (20) hours must be in accordance with Rule 5.0 of these rules and regulations;

2.5.4 Fee payable to the State of Delaware.

2.6 To apply for reinstatement of an expired license, an applicant shall submit (within three (3) years of the expiration date):

2.6.1 A completed application for renewal;

2.6.2 Proof of continuing education attained within the past two years (20 contact hours). The twenty (20) hours must be in accordance with Rule 3.0 of these rules and regulations;

2.6.3 Licensure and late fee payable to the State of Delaware.

6 DE Reg. 1331 (4/1/03)

9 DE Reg. 1768 (5/1/06)

3.0 Continuing Education

3.1 Continuing Education Content Hours

3.1.1 Continuing education (CE) is required for license renewal and shall be completed by ~~May~~ July 31st of each renewal year. ~~A licensee who completes continuing education that is not approved by the Board will be notified so that he or she may obtain additional CE to substitute before the license expiration date of July 31.~~

3.1.1.1 Proof of continuing education is satisfied with an attestation by the licensee that he or she has satisfied the requirements of Rule 3.0;

3.1.1.2 Attestation may be completed electronically if the renewal is accomplished online. In the alternative, paper renewal documents that contain the attestation of completion can be submitted;

3.1.1.3 Licensees selected for random audit are required to supplement the attestation with attendance verification as provided in 3.1.2.

3.1.2 ~~A log of CE on a form approved by the Board shall be maintained during the licensure period to be submitted if the renewal application is selected for CE audit. Random audits will be performed by the Board to ensure compliance with the CE requirement. Licensees selected for the random audit shall submit the log and attendance verification.~~

3.1.2.1 The Board will notify licensees within sixty (60) days after July 31 of each biennial renewal period that they have been selected for audit.

3.1.2.2 Licensees selected for random audit shall be required to submit verification within ten (10) days of receipt of notification of selection for audit.

3.1.2.3 Verification shall include such information necessary for the Board to assess whether the course or other activity meets the CEU requirements in Section 3.0, which may include, but is not limited to, the following information:

3.1.2.3.1 Proof of attendance. While course brochures may be used to verify contact hours, they are not considered to be acceptable proof for use of verification of course attendance;

3.1.2.3.2 Date of CEU course;

3.1.2.3.3 Instructor of CEU course;

3.1.2.3.4 Sponsor of CEU course;

3.1.2.3.5 Title of CEU course; and

3.1.2.3.6 Number of hours of CEU course.

3.1.3 Contact hours shall be prorated for new licensees in accordance with the following schedule:

3.1.3.1 *21 months up to and including 24 months remaining in the licensing cycle requires 20 hours

3.1.3.2 *16 months up to an including 20 months remaining in the licensing cycle requires 15 hours

3.1.3.3 *11 months up to and including 15 months remaining in the licensing cycle requires 10 hours

3.1.3.4 *10 months or less remaining in the licensing cycle - exempt

3.2 Definition of Acceptable Continuing Education Credits:

Activities must be earned in two (2) or more of the six (6) categories for continuing education beginning in section 5.5.

3.3 Continuing Education Content:

3.3.1 Activities must be in a field of health and social services related to occupational therapy, must be related to a licensee's current or anticipated roles and responsibilities in occupational therapy, and must directly or indirectly serve to protect the public by enhancing the licensee's continuing competence.

3.3.2 Approval will be at the discretion of the Board. A licensee or continuing education provider may request prior approval by the Board by submitting an outline of the activity at least six weeks before it is scheduled. The Board pre-approves continuing education activities sponsored or approved by AOTA or offered by

AOTA-approved providers as long as the content is not within the exclusion in Rule 5.5.1 for courses covering documentation for reimbursement or other business matters.

3.3.3 CE earned in excess of the required credits for the two (2) year period may not be carried over to the next biennial period.

3.4 Definition of Contact Hours:

3.4.1 "Contact Hour" means a unit of measure for a continuing education activity. One contact hour equals 60 minutes in a learning activity, excluding meals and breaks."

3.4.2 One (1) academic semester hour shall be equal to fifteen (15) contact hours.

3.4.3 One (1) academic quarter hour shall be equal to ten (10) contact hours.

3.4.4 The preparing of original lectures, seminars, or workshops in occupational therapy or health care subjects shall be granted one (1) contact hour for preparation fro each contact hour of presentation. Credit for preparation shall be give for the first presentation only.

3.5 Continuing Education Activities:

3.5.1 Courses: The maximum credit for course work shall not exceed nineteen (19) hours. Extension courses, refresher courses, workshops, seminars, lectures, conferences, and non patient-specific in-service training qualify under this provision as long as they are presented in a structured educational experience beyond entry-level academic degree level and satisfy the criteria in 5.3.1. Excluded are any job related duties in the workplace such a fire safety, OSHA or CPR. Also excluded are courses covering documentation for reimbursement or other business matters.

3.5.1.1 Course work involving alternative therapies shall be limited to five(5) hours,

3.5.1.2 Course work by homestudy/ correspondence shall be limited to ten (10) hours,

3.5.2 Professional Meetings & Activities: The maximum number of credit hours shall not exceed ten (10) hours. Approved credit includes attendance at: DOTA business meetings, AOTA business meetings, AOTA Representative Assembly meetings. NBCOT meetings, OT Licensure Board meetings and AOTA National Round Table discussions. Credit will be given for participation as an elected or appointed member/officer on a board, committee or council in the field of health and social service related to occupational therapy. Seminars or other training related to management or administration are considered professional activities. Excluded are any job related meetings such a department meetings, supervision of students and business meetings within the work setting.

3.5.3 Publications: The maximum number of credit hours shall not exceed fifteen (15) hours. These include writing chapters, books, abstracts, book reviews accepted for publication and media/ video for professional development in any venue.

3.5.4 Presentations: The maximum number of credit hours shall not exceed fifteen (15) hours. This includes workshops and community service organizations presentations that the licensee presents. Credit will not be given for the presentation of information that the licensee has already been given credit for under another category. Excluded are presentations that are part of a licensee's job duties. The preparation of original lectures, seminars, or workshops in occupational therapy or health care subjects shall be granted one (1) hour for preparation for each contact hour of presentation. Credit for preparation shall be given for the first presentation only.

3.5.5 Research/Grants: Credit may be awarded one time for contact hours per study/topic regardless of length of project, not to exceed ten (10) hours. Contact hours accumulated under this category may not be used under the publication category. Licensees must submit documentation of authorship or letters from authorizing entity to receive continuing education credit.

3.5.6 Specialty Certification: Approval for credit hours for specialty certification, requiring successful completion of courses and exams attained during the current licensure period will be at the discretion of the Board. Examples include Certified Hand Therapist (CHT) and Occupational Therapist, Board Certified in Pediatrics (BCP).

3.6 The Board may waive or postpone all or part of the continuing education activity requirements of these regulations if an occupational therapist or occupational therapy assistant submits written request for a waiver and provides evidence to the satisfaction of the Board of an illness, injury, financial hardship, family hardship, or other similar extenuating circumstance which precluded the individual's completion of the requirements.

6 DE Reg. 1331 (4/1/03)

9 DE Reg. 1768 (5/1/06)

***Please Note:** As the rest of the sections were not amended, they are not being published. A complete set of the rules and regulations for the Board of Occupational Therapy is available at: <http://www.state.de.us/research/AdminCode/title24/2000%20Board%20of%20Occupational%20Therapy.shtml#TopOfPage>

**DIVISION OF PROFESSIONAL REGULATION
2700 Board of Professional Land Surveyors**

Statutory Authority: 24 Delaware Code, Section 2706 (24 **Del.C.** §2706(a))
24 **DE Admin. Code** 2700

PUBLIC NOTICE

The Delaware Board of Professional Land Surveyors in accordance with 24 **Del.C.** §2706(a)(1) has proposed revisions to its rules and regulations. The proposed revisions to the Rules and Regulations are being updated to enable licensees to renew their licenses on line, attest that they have completed the required continuing education and change the period of late renewal of licenses. Documentation of having completed the required continuing education must still be maintained by the licensee but it will only be required to be produced in the event the licensee is randomly selected for continuing education audit post renewal.

A public hearing will be held on March 15, 2007 at 8:30 a.m. in the second floor conference room A of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware where members of the public can offer comments. Anyone wishing to receive a copy of the proposed rules and regulations may obtain a copy from the Delaware Board of Professional Land Surveyors, 861 Silver Lake Boulevard, Cannon Building, Suite 203, Dover, DE 19904. Persons wishing to submit written comments may forward these to the Board at the above address. The final date to receive written comments will be at the public hearing.

The Board will consider promulgating the proposed regulations at its regularly scheduled meeting following the public hearing.

2700 Board of Registration for Professional Land Surveyors

1.0 General Provisions

1.1 Pursuant to 24 **Del.C.** Ch. 27, the Delaware Board of Professional Land Surveyors ("the Board") is authorized to, and has adopted, these Rules and Regulations. The Rules and Regulations are applicable to all Professional Land Surveyors and applicants to the Board.

1.2 Information about the Board, including its meeting dates, may be obtained by contacting the Board's Administrative Assistant at the Division of Professional Regulation. Requests to the Board may be directed to the same office or visit our web site at www.professionallicensing.state.de.us, www.dpr.delaware.gov.

1.3 The Board's President shall preside at all meetings of the Board and shall sign all official documents of the Board. In the President's absence, the Board's Secretary shall preside at meetings and perform the duties usually performed by the President.

1.4 The Board may seek counsel, advice and information from other governmental agencies and such other groups as it deems appropriate.

1.5 The Board may establish such subcommittees as it determines appropriate for the fair and efficient processing of the Board's duties.

1.6 The Board reserves the right to grant exceptions to the requirements of the Rules and Regulations upon a showing of good cause by the party requesting such exception, provided that the exception is not inconsistent with the requirements of 24 **Del.C.** Ch. 27.

1.7 Board members are subject to the provisions applying to "honorary state officials" in the "State Employees', Officers' and Officials' Code of Conduct," found at 29 **Del.C.** Ch. 58.

2.0 Definitions

Definitions under Section 2 will be listed in the current "Definitions of Surveying and Associated Terms," published by the American Congress on Surveying and Mapping, except as otherwise provided by Delaware law.

“Combined Office and Field Experience” - is defined as being multi-faceted experience in responsible charge of land surveying projects, performed under the direct supervision of a professional land surveyor in the active practice of land surveying. The office aspect of this experience shall include the technology relevant to civil drafting, mathematical calculations necessary for subdivision, boundary and right-of-way determinations, road, design, stormwater, sediment and erosion control, and sewer design as well as the interpolation of field-run topographical data and the like. Office experience should also include applied familiarity with land development submittal and approval processes.

The subject field experience shall include time spent in responsible charge relevant to all aspects of on-site inspection, evaluation and field-gathered information as well as the supervision of crew personnel and communication and coordination with a professional land surveyor and office staff.

“Direct Supervision” - applies to one duly licensed as a Professional Land Surveyor (PLS) and only a licensee may provide direct supervision. The physical presence of a PLS on every type of surveying project is not required. There are, however, times when a site visit is necessary to make important decisions involving boundary retracements, property line disputes, etc.

Direct supervision of a party chief and field crew would require daily contact to determine the need for the presence of a PLS on site. This need would be based upon the type of work to be performed and the professional judgment of the PLS in charge. Should it be determined that a site visit is not warranted, the PLS, at a minimum, should instruct the field crew as to the procedures to be used, the data to be gathered, the maps or plats to be relied upon and the scope of the work to be performed. At the end of the assignment, all work should be reviewed and checked by the PLS.

While it has been argued that a survey crew does not always have to be under the direct supervision of a PLS, it is the Board's opinion that only a PLS has the ability to make that determination. It is therefore necessary for the field crew to have daily contact with the PLS so that this decision can be made properly, in order to protect the public.

“Related Science Curriculum” - are those courses of study for which one-third of the required core courses are the same or similar as those required for a Baccalaureate Degree Program in Surveying. These core courses may include but are not limited to Algebra, Trigonometry, Analytical Geometry, Calculus, General Physics and Computer Programming.

Degrees in related fields of study may include but not be limited to Civil Engineering, Mathematics, Physics, Agricultural Engineering, Actuarial Studies, Statistics, Geology and Forestry.

Because requirements for graduation differ from institution to institution, when considering these Related Science Curriculums attention will be given to the specific coursework completed. This examination of completed coursework may allow for greater flexibility of this definition. Section 2708(a).

“Surveying Curriculum” - For the purpose of these regulations, the term "Surveying Curriculum" will mean any approved curriculum for a Baccalaureate Degree in Surveying as it is accepted by the institution bestowing the said degree. This curriculum shall necessarily include but not be limited to courses in Surveying, Advanced Surveying, Legal Principles of Surveying, Data Adjustment, Subdivision Planning and Layout, Route and Construction Surveying, Engineering and Geodetic Astronomy, Topographic Surveying and Cartography and/or those other studies required by the institution where the degree is earned.

Independent study course work (which includes all correspondence, internet and distance-learning study) shall be considered only if those courses have been accepted by an Accreditation Board for Engineering and Technology (ABET) as part of the approved curriculum. Section 2708(a).

(Break in Continuity of Sections)

5.0 Designation of the National Examination

For the required National Examination for licensure under 24 **Del.C.** Ch. 27, the Board adopts the two-part examination developed by the National Council of Examiners for Engineering and Surveying (NCEES), consisting of the Principles and Practice of Land Surveying Examination and the Fundamentals of Land Surveying Examination, as amended from time to time (then in effect at time of examination). Section 2706(a)(3).

6.0 Designation of the Drainage Examination/Delaware Law Examination

6.1 For the required drainage examination/Delaware law examination the Board adopts the bank of questions developed for this purpose and/or approved for this purpose by a recognized psychometrician or other

authority whose services are acquired and approved by the Division of Professional Regulation of the Delaware Department of ~~Administrative Services~~ State. Section 2706(a)(4).

- 6.2 Exam review procedures.
 - 6.2.1 An applicant may review only the questions answered incorrectly.
 - 6.2.2 No other materials will be allowed into the room when reviewing the exam.
 - 6.2.3 There will be a 30-minute time limit supervised by the Division of Professional Regulation.
 - 6.2.4 The fee will be determined by the Division of Professional Regulation.
 - 6.2.5 An applicant cannot review the exam within 90 days prior to the next exam date.
 - 6.2.6 An exam review will be limited to only one review.

(Break in Continuity of Sections)

10.0 Continuing Education

10.1 Biennium Requirements.

Effective ~~July 1, 1995~~ each biennium, as a condition for renewal of a Certificate of Registration for the practice of land surveying, a Professional Land Surveyor shall be required to successfully complete 24 hours of professional development within the preceding biennium. Any licensee who completes in excess of 24 hours of professional development within the preceding biennium may NOT have the excess, ~~not to exceed 12 hours~~, applied to the requirements for the next biennium.

10.2 A licensee shall complete at least two (2) hours on ethics and professionalism for each renewal period with no carry-over credit effective for any biennium with the 7/1/03 through 6/30/05 renewal period.

10.3 Sources of Credit. In reviewing and approving applications for PDHs, the Board shall take into consideration:

10.3.1 Program Content: Courses must cover land surveying topics and must directly contribute to accomplishment of the primary purpose of continuing education, which is to help assure that licensees possess the knowledge, skills and competence necessary to function in a manner that protects and serves the public interest. The knowledge or skills taught must enable licensees to better serve surveying clients and the subject matter must be directly related to the land surveying practice. All educational courses must be approved by the Board.

10.3.2 Instruction: Except as set forth below, the course must be one that will be conducted by a qualified instructor who will be able to interact directly either in person or by interactive television with all students at all times during the course. The course may be conducted through the use of interactive television or other media which permits continuous mutual communication between the instructor and all students, continuous observation of the instructor by all students, and continuous observation of all students by the instructor. Distance education courses may be acceptable when the sponsor gives the licensee a final exam and sends verification to the Board that the licensee has completed the course with a passing grade.

10.3.2.1 Distance education courses are defined as programs whereby instruction does not take place in a traditional classroom setting but rather through other media where teacher and student are apart. Distance education may not be utilized with the exceptions of interactive television and verified courses described above.

- 10.3.3 Examples of topics that are acceptable, but not limited to:
- ALTA/ACSM land title surveys
 - GPS (survey related)
 - GIS (survey related)
 - Delaware land use laws
 - Case law
 - Boundary laws and regulations
 - Research
 - Evidence
 - Boundary determination
 - Unwritten rights
 - Conflict resolution; i.e. boundary line agreements
 - Adverse possession
 - Highway surveys

Railroad surveys
Easements and rights of way
Geodesy
Highway design/Highway safety
Surveyor in court/Expert testimony
State and international boundaries
Water boundaries
Technical writing related to deed descriptions and survey reports
Mathematics and computer applications of land surveying
Measurement and analysis
Photogrammetry and aerial photo interpretation
Survey standards
Survey instrumentation
Business management and professional development related to the land surveying practice; i.e. surveying contracts, communicating with clients, good business planning and management, quality assurance
Ethics and professionalism
Liability for land surveyors
Drainage design
Sediment and erosion control
First aid/CPR

10.3.4 Serving as a member of a committee or a board or a commission, which has as its primary duty the preparation or grading of written tests which are given for the purpose of determining the proficiency of an applicant for registration, using accepted test development principles, shall be counted as one (1) PDH per hour of attendance.

10.3.5 Attendance at workshops or seminars, which are directly related to land surveying, shall count as one (1) PDH per actual hour of classroom attendance. Such sessions must be planned in advance, a record must be maintained describing the content and a record of attendance must be kept. This may include society meetings in which educational programs are presented.

10.3.6 The active teaching of land surveying at the college level, within the immediate preceding biennium, shall be counted as eight (8) PDHs per year. No more than sixteen (16) PDHs shall be issued for teaching at the college level in any renewal period. CREDIT WILL NOT BE GIVEN TO FULL TIME EDUCATORS.

10.3.7 Teaching a workshop or seminar, which is directly related to land surveying or professional development, shall be counted as two (2) PDHs per actual hour of teaching time, not to include preparation. No more than eighteen (18) PDHs may be claimed in any 2-year period. CREDIT WILL BE GIVEN FOR ONLY ONE PRESENTATION IN A TWO-YEAR PERIOD.

10.3.8 College level courses directly related to land surveying or professional development shall be counted as 40 PDH per credit hour. Ten (10) PDHs will be counted for each CEU (continuing education unit) earned.

10.3.9 Presentation and/or publication of a professional paper will be counted as 10 PDHs. No more than 20 PDHs may be claimed in any biennium renewal.

10.4 Renewal Credit.

10.4.1 Each licensee applying for renewal shall ~~be required~~ attest to satisfying the continuing education requirements outlined in Rule 10.1, 10.2, and 10.3, submit on the Board approved form of his/her professional development hours obtained in the period defined in Section 10.1 of these rules. Should the licensee desire to have any excess PDHs applied to the requirement for the next biennium, it shall be so stated in the space provided on said form. Attestation may be completed electronically if the renewal is accomplished online. In the alternative, paper renewal documents that contain the attestation of completion can be submitted on the Board approved form of his/her professional development hours obtained in the period defined in Section 10.1 of these rules. Should the licensee desire to have any excess PDHs applied to the requirement for the next biennium, it shall be so stated in the space provided on said form.

10.4.2 If the Board should, for any reason, deny or modify the licensee's request for ~~carryover~~ PDHs, the Board shall notify the licensee of such action after the next Board meeting. The licensee's

submittal shall be on a form provided by the Board and shall contain a statement signed and sealed by the licensee, which attests to the correctness thereof. Such statement shall accompany and be filed with the licensee's request for renewal. Licensees should retain their PDH files and records for at least five (5) years.

10.5 Pro-Rated Credits for Renewal. A licensee for renewal shall follow the following schedule of reporting PDH credits: if, at the time of renewal, you have been licensed for less than one year, NO continuing education is required; licensed for more than one year, but less than two years, half (12 PDHs) is required; licensed for two or more years, the full amount (24 PDHs) is required.

10.6 Renewal. Any licensee who has submitted a correctly completed paper or electronic renewal form as required in Section 10.4.1 and has met all other requirements shall be granted renewal.

10.7 Audit. Each biennium, the Division of Professional Regulation shall select from the list of potential renewal licensees a percentage, determined by the Board, which shall be selected by random method. The Board may also audit based on complaints or charges against an individual license, relative to compliance with continuing education requirements.

10.8 Documentation and Audit by the Board. When a licensee whose name or number appears on the audit list applies for renewal, the Board shall obtain documentation from the licensee showing detailed accounting of the various PDHs claimed by the licensee. Licensees selected for random audit are required to supplement the attestation with attendance verification. The Board shall attempt to verify the PDHs shown on the documentation provided by the licensee. The Board shall then review the documentation and verification. Upon completion of the review, the Board shall decide whether the licensee's PDHs meet the requirements of these rules and regulations.

10.9 Board Review. The Board shall review all documentation requested of any licensee shown on the audit list. If the Board determines the licensee has met the requirements, the licensee's certificate of registration shall remain in effect. If the Board initially determines the licensee has not met the requirements, the licensee shall be notified and a hearing may be held pursuant to the Administrative Procedures Act. This hearing will be conducted to determine if there are any extenuating circumstances justifying the apparent noncompliance with these requirements. Unjustified noncompliance of these regulations shall be considered misconduct in the practice of land surveying, pursuant to 24 **Del.C.** §2712.

10.10 Noncompliance – Extenuating Circumstances. A licensee applying for renewal may request an extension and be given up to an additional twelve (12) months to make up all outstanding required PDHs providing he/she can show good cause why he/she was unable to comply with such requirements at the same time he/she applies for renewal. The licensee must state the reason for such extension along with whatever documentation he/she feels is relevant. The Board shall consider requests such as extensive travel outside the United States, military service, extended illness of the licensee or his/her immediate family, or a death in the immediate family of the licensee. The written request for extension must accompany the renewal application. The Board shall issue an extension when it determines that one or more of these criteria have been met or if circumstances beyond the control of the licensee have rendered it impossible for the licensee to obtain the required PDHs. A licensee who has successfully applied for an extension under this paragraph shall make up all outstanding hours of professional development within the extension period approved by the Board.

10.11 Appeal. Any licensee denied renewal pursuant to these rules and regulations may contest such ruling by filing an appeal pursuant to the Administrative Procedures Act.

10.12 Retired Licensees. Licensees 62 years old and over who are retired (working less than 20 hours weekly) shall need only twelve (12) PDHs, including one ethics PDH, each biennium to satisfy the professional development requirements outlined herein.

10.13 Multiple State Licensees. Any licensee, who is not a Delaware resident and resides in another state or commonwealth, and is licensed in that state or commonwealth having a comparable continuing education requirement, shall not be required to satisfy these requirements in addition to those of his/her home state, but will satisfy these requirements as a minimum. Any questions regarding compliance with this Section shall be resolved by the Board.

6 DE Reg. 271 (9/1/02)

(Break in Continuity of Sections)

16.0 Renewal of Lapsed Licenses

A licensee may renew a license that has lapsed after the renewal date, by payment of the late fee penalty and proof of the required PDHs to the Division of Professional Regulation, if the licensee files for renewal within

~~two calendar years~~ six (6) months of the most recent renewal date. A licensee who does not file for renewal within that period must re-apply for a new license. Section 2711.

***Please Note: As the rest of the sections were not amended, they are not being published. A complete set of the rules and regulations for the Board of Professional Land Surveyors is available at: <http://www.state.de.us/research/AdminCode/title24/2700%20Board%20of%20Land%20Surveyors.shtml#TopOfPage>**

DIVISION OF PROFESSIONAL REGULATION 3500 Board of Examiners of Psychologists

Statutory Authority: 24 Delaware Code, Section 3506(a)(1) (24 **Del.C.** §3506(a)(1)
24 **DE. Admin. Code** 3500

PUBLIC NOTICE

The Delaware Board of Examiners of Psychologists in accordance with 24 **Del.C.** §3506(a)(1) has proposed changes to its rules and regulations to allow for online renewal of licenses and online attestation of completion of continuing education hours. The proposed changes also provide for a post-renewal audit, so that licensees have the full two-year period to obtain required continuing education. Under the proposed rules, licensees may earn continuing education through the July 31 deadline. In addition, the proposed rules specify the number of continuing education credits required for newly-licensed individuals. The proposed rules also clarify the information that must be submitted to the Board to obtain licensure. Finally, the proposed revisions implement the recent changes to the reciprocity provisions of the Board's statute, 24 **Del.C.** §3511. These changes allow professionals that have passed the required examination and have been licensed in another state for at least two continuous years to satisfy the requirements of licensure in Delaware by submitting information showing that they hold a current Certificate of Professional Qualification in Psychology (CPQ) issued by the Association of State and Provincial Psychology Boards (ASPPB), or are currently credentialed by the National Register of Health Service Providers in Psychology.

A public hearing will be held on March 5, 2007 at 9:30 a.m. in the second floor conference room A of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware, where members of the public can offer comments. Anyone wishing to receive a copy of the proposed rules and regulations may obtain a copy from the Delaware Board of Examiners of Psychologists, 861 Silver Lake Blvd, Cannon Building, Suite 203, Dover, DE 19904. Persons wishing to submit written comments may forward these to the Board at the above address. The final date to receive written comments will be at the public hearing.

The Board will consider promulgating the proposed regulations at its regularly scheduled meeting following the public hearing.

3500 Board of Examiners of Psychologists

(Break in Continuity of Sections)

5.0 Procedures for Licensure

5.1 Application - Initial Licensure

The applicant must submit the following:

5.1.1 An applicant who is applying for licensure as a psychologist shall submit evidence showing that he/she meets the requirements of 24 **Del.C.** §3508. An application for licensure, which shall include:

5.1.1.1 Academic credentials documented by official transcripts showing completion of an educational program meeting the requirements of 24 **Del.C.** §3508(a)(1).

5.1.1.2 Supervised experience documented by having each supervisor complete a Supervisory Reference Form.

5.1.1.3 Evidence that the applicant passed the written "Examination for Professional Practice in Psychology", developed by the Association of State and Provincial Psychology Boards (ASPPB), by achieving the passing score recommended by the ASPPB for that particular examination (computer or paper) administration. Candidates who are not licensed in any other state must have passed the written examination within five (5) years of application for licensure in Delaware. Applicants who have not taken the examination must submit all other required documents to the Board for review prior to sitting for the examination. Only those applicants the Board determines are otherwise eligible for Delaware licensure shall be approved to sit for the examination, subject to the administration policies and procedures of the ASPPB. After sitting for the examination, applicants must supplement their application materials by submitting evidence of their passing score as recommended by the ASPPB.

5.1.1.4 Verification that the applicant has no past or pending disciplinary proceedings.
[24 Del.C. §3508(a)(4)]

5.1.1.5 The application shall not be considered complete until all materials are received by the Board for review at an officially scheduled meeting. The applicant will have twelve (12) months from the date of initial submission of the application and fee to complete the application process.

~~5.1.2 Completed certification form. The applicant will be notified, once his/her application is complete and available for the Board's review. The certification form must be submitted before any further action can be taken.~~

5.2 Application - By Reciprocity

~~An applicant who is applying for licensure as a psychologist by reciprocity, as defined in 24 Del.C. §3511, shall submit evidence that he/she meets the following requirements:~~

5.2.1 An applicant who is applying for licensure as a psychologist by reciprocity shall submit evidence that he/she meets the requirements of 24 Del.C. §3511. An application for licensure, which by reciprocity shall include the following information, or alternatively, the information required by Rule 5.2.2:

5.2.1.1 Evidence that the applicant is licensed or certified in another state and that the applicant has practiced continuously, as a doctoral-level psychologist, in good standing in that jurisdiction for two (2) years.

5.2.1.2 Information identifying all jurisdictions in which the applicant has been or is currently licensed, certified or registered.

5.2.1.23 Evidence that the applicant passed the written Examination for Professional Practice of Psychology (EPPP). The Board shall the passing score recommended by the ASPPB for that particular examination (computer or paper) administration. For examinations taken prior to 1992, the Board shall accept either the ASPPB recommended passing score or the minimum passing score accepted by the Delaware Board in the year the examination was taken, whichever was lower.

5.2.1.4 Evidence that the candidate has received a doctoral degree from an American Psychological Association (APA) accredited program or a doctoral degree based on a program of studies which is psychological in content and specifically designed to train and prepare psychologists, meeting the criteria set forth in Regulation 6.1.1.

~~5.2.2 Completed certification form. The applicant will be notified once his/her application is complete and available for the Board's review. The certification form must be submitted before any further action can be taken.~~ An applicant currently licensed in another state may satisfy the requirements for licensure by reciprocity by submitting information demonstrating that he or she has met the requirements for and holds a current Certificate of Professional Qualification in Psychology (CPQ) issued by the Association of State and Provincial Psychology Boards (ASPPB), or he or she is currently credentialed by the National Register of Health Service Providers in Psychology. Applicants under this section shall complete a brief application on a form approved by the Board.

5.3 Computer Based Testing Procedures*

5.3.1 The EPPP ~~will be~~ is offered by computerized delivery ~~beginning in 2004~~. An applicant for examination shall complete an application for computer based-testing, available from the Board.

5.3.2 Once a candidate has been approved to sit for the EPPP by the Board, the Board shall forward a notice of approval to the examination service, which will then forward instructions to the examination candidate.

5.3.3 It shall be the responsibility of the applicant to schedule his or her EPPP administration with a test delivery site pursuant to the instructions given by the examination service.

5.3.4 The examination service will forward test results directly to the Board. Test results will not be available to the candidate at the testing center, nor will test results be given over the phone.

5.3.5 The Board shall notify the applicant of his or her examination score, and pass/fail status upon receipt of this information from the testing service.

5.3.6 If an applicant has been approved to sit for the EPPP by a jurisdiction other than Delaware, it shall be the responsibility of the applicant to arrange to have the score transferred to the Delaware Board.

5.3.7 An applicant who fails the examination may re-take the exam no sooner than 60 days after the prior examination date. An applicant may take the examination a maximum of four (4) times in any 12 month period. [24 Del. C. §§ 3506(a)(4).]

~~* This rule shall take effect upon implementation of the computer based EPPP by ASPPB. The expected implementation date is April 2001.~~

3 DE Reg 1067 (2/1/00)

4 DE Reg. 979 (12/1/00)

4 DE Reg. 1794 (5/1/01)

(Break in Continuity of Sections)

10.0 Continuing Education

10.1 Hours required.

10.1.1 Psychologists must obtain 40 hours of continuing education every two years during each biennial licensing period in order to be eligible for renewal of license. The biennial licensing period begins August 1 of each odd-numbered year and ends July 31 of the next odd-numbered year. Psychologists will be notified in January that they may submit their documentation beginning March 1st. Continuing education credit must be submitted for the period of August 1st of the year of renewal to July 31st of the second year. Individuals licensed within the two year period will be notified by the Board of the prorated amount to submit.

10.2 Psychological assistants must obtain 20 hours of continuing education every two years during each biennial licensing period for re-registration. Psychological assistants may submit their documentation beginning March 1st. The appropriate period for credits to be accrued is from August 1st of the year of renewal to July 31st of the second year. Psychological assistants registered within the two year period will be notified by the Board of the prorated amount to submit.

10.2 Proration of CE Requirement for New Licensees

10.2.1 The CE requirement for a licensee's initial licensing period shall be prorated as follows:

10.2.1.1 If an applicant is granted a psychologist license during the first six months of a license period, i.e., between July 31 of an odd-numbered year and January 31 of the next year, the new licensee must complete 30 CEs. An applicant granted a psychological assistant license in the same time period must complete 15 CEs in the initial licensing period.

10.2.1.2 If an applicant is granted a psychologist license during the second six months of a license period, i.e., between February 1 of an even-numbered year and July 31 of that same year, the new licensee must complete 20 CEs. An applicant granted a psychological assistant license in the same time period must complete 10 CEs in the initial licensing period.

10.2.1.3 If an applicant is granted a psychologist license during the third six months of a license period, i.e., between the dates of August 1 of an even-numbered year and January 31 of the next year, the licensee must complete 10 CEs. An applicant granted a psychological assistant license in the same time period must complete 5 CEs in the initial licensing period.

10.2.1.4 Any applicant granted a license during the last six months of a license period, i.e., between the dates of February 1 of an odd-numbered year and July 31 of that same year, need not complete any CEs during that period.

10.3 Psychologists or psychological assistants who have not submitted their material by July 31st will be allowed to reapply for licensure or registration until August 31st. In the situation where the appropriate amount of documentation has been submitted in a timely fashion and in good faith and with reasonable expectation of renewal, but has been found to be inadequate, the practitioner has 30 days from the notification of inadequacy to submit valid continuing education credit in the amount specified, or until August 31st of that year, whichever is later. Hardship. An applicant for license renewal or registered psychological assistant may be granted an extension of

time in which to complete continuing education hours upon a showing of ~~good cause~~ hardship. "Good cause" Hardship may include, but is not limited to, disability, illness, extended absence from the jurisdiction and exceptional family responsibilities. Requests for hardship consideration must be submitted to the Board in writing prior to the end of the licensing period, along with payment of the appropriate renewal fee. No extension shall be granted for more than 120 days after the end of the licensing period. A license shall be renewed upon approval of the hardship extension by the Board, but the license shall be subject to revocation if the licensee does not complete the requisite continuing education pursuant to the terms of the extension.

10.4 It is the responsibility of the psychologist or psychological assistant to ~~file~~ maintain a record documentation of his/her continuing education ~~for one year after the licensing period expires~~. Documentation of continuing education will consist of ~~letters/ certificates of attendance from the sponsoring entity~~ the information specified in 13.4.3.

10.5 The subject of the continuing education must contribute directly to the professional competency of a person licensed to practice as a psychologist or registered as a psychological assistant. The activity must have significant intellectual or practical content and deal with psychological techniques, issues or ethical standards relevant to the practice of psychology.

10.6 Activities from APA-approved continuing education sponsors will be automatically accepted. The following may be eligible:

10.6.1 Other programs which are not APA-approved sponsors but where the material is relevant to professional practice and provides the equivalent of APA-defined credit. An applicant must provide a brochure or other documentation that supports the following criteria: relevance, stated objectives, faculty and educational objectives. To document attendance and completion, a certificate of attendance is required. In these circumstances, hours will be accrued on the basis of clock hours involved in the training.

10.6.2 Graduate courses relevant to professional practice taken for educational credit offered by a regionally accredited academic institution of higher education. Each credit hour of a course is equivalent to 5 CE hours.

10.6.3 Teaching an undergraduate or graduate level course in applied psychology at an accredited institution. Teaching a 3 hour semester or quarter course is considered the equivalent of 5 CE credits. No more than 5 CE credits may be completed in this manner for any renewal period and can be submitted only for the first time that a course is presented. Appropriate documentation of teaching must include the listing of the course in the school catalog and a letter from the academic institution stating that the course was taught.

10.6.4 Teaching of a workshop or conduction of a seminar on a topic of pertinence to the practice of psychology. Credit earned for one day is a maximum of 2 credits, two days is a maximum of 3 credits, and three days or more is a maximum of 5 credits. However, credit can be earned only once for teaching a particular seminar or workshop and not be eligible for re-submission at any time. Appropriate documentation is considered to be the brochure and demonstration of the workshop being held by the sponsoring entity.

10.6.5 Authorship, editing or reviewing of a publication. Credit may be earned only in the year of the publication and is limited to the following:

10.6.5.1 Author of a book (maximum of 40 CE hours)

10.6.5.2 Author of a book chapter or journal article (maximum of 15 CE hours)

10.6.5.3 Editor of a book (maximum of 25 CE hours)

10.6.5.4 Editor of or reviewer for a scientific or professional journal recognized by the Board (maximum 25 CE hours)

10.6.5.5 Proof of the above (10.6.5.1 - 10.6.5.4) must include the submission of the work or documentation of authorship by copy of title pages.

10.6.6 Preparing and presenting a scientific or professional paper or poster at a meeting of a professional or scientific organization. Up to 2 hours may be claimed for a poster presentation. Up to 3 hours of credit may be claimed for each hour of paper presentation, with a maximum of 8 CE hours per paper. Listing within the program and certificate letters of attendance at the meeting is appropriate documentation for both a paper or poster presentation.

10.7 The Board reserves the right to reject any CE program, if it is outside the scope of the practice of psychology.

10.8 The following will not be considered for credit: service to organizations; attending business meetings of professional organizations; business management or office administration courses; group supervision; or case conferences.

2 DE Reg. 776 (11/1/98)

4 DE Reg. 983 (12/1/00)

(Break in Continuity of Sections)

13.0 License Renewal

13.1 Renewal notices will be mailed to the current address on file in the Board's records in a timely fashion to all psychologists and psychological assistants who are currently licensed or registered. It shall be the responsibility of each psychologist and psychological assistant to advise the Board, in writing, of a change of name or address.

13.2 Continuing education requirements must be fulfilled as detailed in Section 10.0 of the Rules and Regulations and submitted along with the established fee for renewal to be approved. The Board may, in its discretion, grant a license renewal under the terms of a continuing education hardship extension pursuant to rule 10.3. ~~Should any psychologist fail to renew or obtain a hardship extension and continue to make representation as a licensed psychologist beyond July 31st, that individual is practicing without a license. Should any psychological assistant fail to renew or obtain a hardship extension and continue to make representation as a registered psychological assistant beyond July 31st, that individual is considered no longer to be registered, and his/her supervising psychologist is in violation of the law.~~

13.3 If a psychologist or a psychological assistant fails to renew or obtain a hardship exception by July 31, he or she may renew at any time until August 31 of that same year, upon payment of a late fee. In accord with Section 3507(b), whenever a license to practice or registration has expired, it is unlawful for the licensee/registration to practice while the license or registration is expired.

13.4 Proof of continuing education is satisfied with an attestation by the licensee that he or she has satisfied the requirements of Rule 10.0.

13.4.1 Attestation may be completed electronically if the renewal is accomplished online. In the alternative, paper renewal documents that contain the attestation of completion may be submitted.

13.4.2 Licensees selected for random audit will be required to supplement the attestation with attendance verification pursuant to Rule 7.4.

13.5 Random post-renewal audits will be performed by the Board to ensure compliance with the CE requirements.

13.5.1 The Board will notify licensees within sixty (60) days after the end of a license renewal period (July 31 of odd-numbered years) that they have been selected for audit.

13.5.2 Licensees selected for random audit shall be required to submit verification within ten (10) days of receipt of notification of selection for audit.

13.5.3 Verification shall include such information necessary for the Board to assess whether the course or other activity meets the CE requirements in Section 10.0, which may include, but is not limited to, the following information:

13.5.3.1 Appropriate documentation as outlined in Rule 10.6; and/or

13.5.3.2 Proof of attendance. While course brochures may be used to verify continuing education hours, they are not considered to be acceptable proof for use of verification of course attendance;

13.5.3.3 Date and location of CE course;

13.5.3.4 Instructor of CE course;

13.5.3.5 Sponsor of CE course;

13.5.3.6 Title of CE course; and

13.5.3.7 Number of hours of CE course.

4 DE Reg. 984 (12/1/00)

***Please Note: As the rest of the sections were not amended, they are not being published. A complete set of the rules and regulations for the Board of Examiners of Psychologists is available at: <http://www.state.de.us/research/AdminCode/title24/3500%20Board%20of%20Examiners%20of%20Psychologists.shtml#TopOfPage>**

Symbol Key

Arial type indicates the text existing prior to the regulation being promulgated. Underlined text indicates new text added at the time of the proposed action. Language which is ~~stricken through~~ indicates text being deleted. **[Bracketed Bold language]** indicates text added at the time the final order was issued. ~~**[Bracketed stricken through]**~~ indicates language deleted at the time the final order was issued.

Final Regulations

The opportunity for public comment shall be held open for a minimum of 30 days after the proposal is published in the **Register of Regulations**. At the conclusion of all hearings and after receipt within the time allowed of all written materials, upon all the testimonial and written evidence and information submitted, together with summaries of the evidence and information by subordinates, the agency shall determine whether a regulation should be adopted, amended or repealed and shall issue its conclusion in an order which shall include: (1) A brief summary of the evidence and information submitted; (2) A brief summary of its findings of fact with respect to the evidence and information, except where a rule of procedure is being adopted or amended; (3) A decision to adopt, amend or repeal a regulation or to take no action and the decision shall be supported by its findings on the evidence and information received; (4) The exact text and citation of such regulation adopted, amended or repealed; (5) The effective date of the order; (6) Any other findings or conclusions required by the law under which the agency has authority to act; and (7) The signature of at least a quorum of the agency members.

The effective date of an order which adopts, amends or repeals a regulation shall be not less than 10 days from the date the order adopting, amending or repealing a regulation has been published in its final form in the **Register of Regulations**, unless such adoption, amendment or repeal qualifies as an emergency under §10119.

DEPARTMENT OF AGRICULTURE
PESTICIDES SECTION

Statutory Authority: 3 Delaware Code, Section 1237 (3 Del.C. §1237)
3 DE Admin. Code 601

ORDER

Pursuant to 3 Del.C. §1237 and 29 Del.C., §§10111-10118, the State of Delaware, Department of Agriculture, proposes the repeal of Regulation 19.0, Delaware Pesticide Rules and Regulations. This Regulation, entitled Antifouling Paint Restrictions, became effective on or about September 1, 1987, in an effort to address environmental and health concerns related to the use of organotins as marine antifouling paints. The Regulation was revised on or about March 1, 1990, to conform with federal law, the federal Organotin Antifouling Paint Act of 1988.

As a result of federal government regulatory action, organotin products are not permitted to be used in the United States, the last registration of an organotin antifouling paint product having been cancelled on or about December 1, 2005 (see Federal Register: February 16, 2005 (Volume 70, Number 31) [Page 7941-7942]). No products are available for use and Regulation 19 is outdated and unnecessary.

The repeal of Regulation 19.0 will result in a "Reserved" section for future use.

Written comments from the public concerning the repeal of Regulation 19 are solicited and should be submitted to the Delaware Department of Agriculture, 2320 S. duPont Hwy., Dover, DE 19901, (attention: H. Grier Stayton) on or before March 2, 2007.

601 Delaware Pesticide Rules and Regulations

(Break in Continuity of Sections)

19.0 Antifouling Paint Restrictions Reserved

19.1 For the purposes of this section, the following definitions shall apply:

~~19.1.1 The term "acceptable release rate" means a measured release rate not to exceed 4.0 micrograms per square centimeter per day and as further defined in the Organotin Anti-fouling Paint Control Act of 1988, (Pub. L. 100-333).~~

~~19.1.2 The term "antifouling paint" means a coating, paint, or treatment that is applied to a vessel or any fishing gear used to catch shellfish or finfish to control fresh water or marine fouling organisms.~~

~~19.1.3 The term "vessel" means every description of watercraft, other than a seaplane, used or capable of being used as a means of transportation on the water, whether self-propelled or otherwise, and includes barges and tugs.~~

~~19.1.4 The term "commercial boat yard" means any facility which engages for hire in the construction, storage, maintenance, repair, or refurbishing of vessels or any licensed independent marine maintenance contractor who engages in such activities.~~

~~19.1.5 The term "organotin" means any compound of tin used as a biocide in an anti-fouling paint.~~

~~19.1.6 The term "retail" means the transfer of title to tangible personal property other than for resale, after manufacturing or processing.~~

~~19.2 Except as otherwise provided in this Section, no person shall distribute, possess, sell, or offer for sale, apply or offer for use or application any marine anti-fouling paint containing organotin.~~

~~19.3 No person may sell or deliver to, or purchase or receive from, another person at retail any substance containing organotin for the purpose of adding such substances to paint to create an anti-fouling paint.~~

~~19.4 A person may distribute or sell a marine anti-fouling paint containing organotin with an acceptable release rate to the owner or agent of a commercial boat yard. The owner or agent of a commercial boat yard may possess and apply or purchase for application an anti-fouling paint containing organotin with an acceptable release rate, however, the paint may be applied only within a commercial boat yard and only to vessels which exceed twenty five meters (82.02 feet) in length or which have aluminum hulls.~~

~~19.5 A person may distribute, sell, or apply a marine anti-fouling paint containing organotin having an acceptable release rate, if the paint is distributed or sold in a spray can in a quantity of sixteen ounces avoirdupois or less and is commonly referred to as outboard or lower unit paint.~~

*** Please note that federal regulatory action renders Section 19.0 unnecessary, as originally published in the November 2006 issue of the *Register* at page 833 (10 DE Reg. 833). Section 19.0, therefore, is being repealed. As the other sections of the regulation are not affected, they are not being republished. For more information, please refer to the November 2006 issue of the *Register* or contact the Department of Agriculture, Pesticides Section. A complete set of the rules and regulations for the Department of Agriculture is available at: <http://www.state.de.us/research/AdminCode/title3/index.shtml#TopOfPage>.**

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 **Delaware Code**, Section 512 (31 **Del.C.** §512)

ORDER

Attendant Services §1915(c) Home and Community-Based Services Waiver Application

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, notice is hereby given that the proposed regulation published in Volume 10, Issue 6 of the December 1, 2006 issue of the *Delaware Register of Regulations* has been withdrawn.

Summary of Withdrawal

On October 31, 2006, the Division of Medicaid and Medical Services (DMMA) submitted a §1915(c) waiver

application to the Centers for Medicaid and Medicaid Services (CMS) for approval. The DMMA announced a thirty-day comment period for this Waiver application in the December 1, 2006 issue.

DMMA withdraws its proposed regulation published on December 1, 2006 at 10 DE Reg. 954 as of February 1, 2007. Eligible clients will continue to be placed in the State's Attendant Services Program. This option offers more services to the client population than would be available under the Waiver.

***For more information, please refer to the December 2006 issue of the *Register* at page 954 (10 DE Reg. 954) or contact the Department of Health and Social Services, Division of Medicaid and Medical Assistance. The rules and regulations for the Department of Health and Social Services are available online at: <http://www.state.de.us/research/AdminCode/title16/index.shtml#TopOfPage>.**

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 **Delaware Code**, Section 512 (31 **Del.C.** §512)

ORDER

Long Term Care Medicaid 20400.9.1.1 Treatment of Special Needs Trusts

NATURE OF THE PROCEEDINGS

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend a rule in the Division of Social Services Manual (DSSM) used to determine eligibility for the Medicaid Long Term Care Program. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the December 2006 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by December 31, 2006 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSED CHANGE

Statutory Authority

Section 1917(d)(4)(A) of the Social Security Act, *Liens, adjustments and recoveries; transfer of assets*

Background

In 1993, Congress created an exception under the amendments to the Omnibus Budget and Reconciliation Act (OBRA '93) which specifically authorized the use of Supplemental Needs Trusts for the benefit of individuals who are under the age of 65 years and disabled according to Social Security standards. The Social Security Operations Manual authorizes the use of Supplemental Needs Trusts to hold non-countable assets. A special needs trust is a revocable or irrevocable trust established with the assets of a client under age 65 who meets the Supplemental Security Income (SSI) program's disability criteria. The trust must be established for the client's benefit by his parent, grandparent, legal guardian, or a court.

Summary of Proposed Change

The purpose of this amendment is to correct a procedural error in the DSSM policy manual and to provide consistency with the Social Security's Program Operations Manual System (POMS) for the purposes of determining eligibility for Long Term Care Medicaid. Guidance for this regulatory action is based on POMS SI 01120.203.

Current policy states *"The Medical Review Team (See Section 20102.2.2) has determined that the*

individual is disabled using the State of Delaware's Determination of Disability for Medicaid procedure." Determining disability is not a function that is performed by the Medical Review Team. The revised policy states that the individual should be disabled according to the SSI standards.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. DMMA has considered each comment and responds as follows:

SCPD understands that the rationale for the amendments is to correct some references to achieve conformity with federal standards. The current regulation literally requires the trust beneficiary to be a current SSI or SSDI beneficiary. To the contrary, federal law only requires the beneficiary to meet SSI medical disability standards.

First, it is preferable for DMMA to delete the reference to conducting the disability assessment based on DDS criteria. SCPD previously endorsed substituting a reference to SSI standards for DDS standards in the context of pooled trusts. See DMMA final regulations adopted at 10 DE Reg. 558 (September 1, 2006).

Agency Response: DMMA acknowledges the concurrence.

Second, it is likewise preferable to delete the requirement that the beneficiary be "receiving either Title II or SSI benefits". The attached SSA POMS SI 01120.203 and Section 1614(a)(3) of the Social Security Act only require that the beneficiary meet SSI medical disability criteria.

Agency Response: The receipt of either Title II or SSI benefits provides staff with the knowledge that the client meets the medical criteria without requiring additional proof.

Third, DMMA's deletion of the reference to the Medical Review Team determining eligibility is problematic. The Division recites as follows:

Determining disability is not a function that is performed by the Medical Review Team. The revised policy states that the individual should be disabled according to the SSI standards.

The concern with these statements is that some expert needs to make a medical decision that the beneficiary meets the SSI medical disability standards. If the beneficiary is a current SSI recipient, then DMMA can simply defer to that status. However, there will be some individuals who are not current SSI recipients who nevertheless meet SSI medical disability standards. If the Medical Review Team will not perform the necessary assessment for such individuals, who will?

For these reasons, DMMA may wish to consider revising its second bullet as follows:

The individual meets the medical disability standards of the SSI program as defined in Section 1614(a)(3) of the Act. For current SSI or SSDI beneficiaries, DMMA will defer to the SSA's determination of medical disability. For non-SSI or SSDI beneficiaries who have already been determined to meet SSI medical disability standards as a prerequisite for eligibility for other DMMA programs (e.g. CCADP), DMMA will defer to that determination. For other individuals, the determination that the individual meets SSI medical disability standards will be made by the Medical Review Team (described in §20102.2.2) or receipt of expert medical certification acceptable to the Division.

Agency Response: See DSSM 20350.10.2 for disability determination criteria. DMMA has made no change to the rule language based on this comment.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the *December 2006 Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual related to proof of disability used in determining eligibility for the Medicaid Long Term Care Program is adopted and shall be final effective February 10, 2007.

Vincent P. Meconi, Secretary, DHSS, 01/16/2007

**DMMA FINAL ORDER #07-05
REVISION:****20400.9 Exceptions to the Trust Eligibility Policy**

Two exceptions to the trust eligibility policy are Special Needs Trusts and Pooled Trusts for disabled individuals.

20400.9.1 Special Needs Trusts

A special needs trust contains the assets of an individual under age 65 who is disabled. It is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual or a court. The trust may also contain the assets of other individuals.

20400.9.1.1 Treatment of Special Needs Trusts

For individuals under age 65 the exceptions to the Medicaid eligibility rules continue even after the individual becomes age 65. No additional assets may be added to the trust after the individual reaches age 65. If assets are added they will not be exempted and are subject to penalties. To qualify as a special needs trust, the following conditions must exist:

- The trust must be established solely for the needs of a disabled individual who is under age 65.
- The individual is ~~receiving either Title II or SSI benefits as a disabled individual. (In this case we would accept the disability determination made for these programs disabled as defined by the SSI program in 1614(a)(3) of the Act.~~
- The trust must be established by the disabled individual's parent(s), grandparent(s), legal guardian(s) or a court.
- ~~The Medical Review Team (See Section 20102.2.2) has determined that the individual is disabled using the State of Delaware's Determination of Disability for Medicaid procedure.~~

In addition to the above criteria, the trust must state that upon the individual's death all remaining assets and funds should be paid to the State agency up to the amount paid in Medicaid benefits on the individual's behalf.

DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Section 311 (18 **Del.C.** 311)
18 **DE Admin. Code** 704

ORDER**704 Homeowners Premium Consumer Comparison**

After publication of proposed Regulation 704 in the *Delaware Register of Regulations* on December 1, 2006, the public comment period on the proposed regulation remained open until January 3, 2007. Public notice of proposed Regulation 704 in the *Register of Regulations* and two newspapers of general circulation was in conformity with Delaware law. Written comments were received into the record from two trade associations that represent insurance companies that write homeowners insurance in the State of Delaware.

Summary of the Evidence and Information Submitted

The proposed regulation was promulgated to provide a method whereby Delaware homeowners insurance consumers would have the ability to compare premium rates of all insurers in Delaware. Each insurer would be required to submit information about its rates in response to a survey established by the Department. Insurers with

less than one percent of the market would be required to fill out a less comprehensive survey. The insurers would be required to maintain records of all estimates provided to consumers and would also be required to provide a direct email response to the consumer confirming receipt of the quote request. All rate data for the website comparison would have to be filed with the Department annually on March 1st of each year except for 2007 when the information would be due by April 1st.

The insurers were generally supportive of public accessibility to such rate comparison data. By and large they were concerned about the amount of detail required by the regulation, the difficulties in providing email receipts and the potential for misunderstandings and unintended reliance by the consumers on the sample rates based on hypothetical situations that did not take into account the specific risks and background information that is already available by direct contact with the consumer. All of the insurers acknowledged that they currently provide direct to consumer rate quotes by telephone or website utilities. The purpose of the regulation would be to allow the consumer to look at rates from several companies on one website rather than or prior to accessing individual company websites or making individual calls to particular insurance companies.

Findings of Fact

Members of the public generally and the insurance consumer in particular have a vested interest in having that information available that will allow the consumer to make an informed and knowledgeable decision about insurance coverage. This regulation allows the consumer to utilize an objective information base that is not sponsored by any insurer or insurance agent. It will be designed with sufficient notice to the consumer that the comparative data is based on sample or hypothetical situations and that the information is not a rate quote or binding upon the particular insurer that submitted the information. Nevertheless, each insurer will be required to provide accurate data as part of their obligations under the regulation. The fact that the data has to be submitted on an annual basis avoids the problems inherent in using stale information. While suggesting different approaches, the insurers were supportive of the public's right to know the premium costs for consumer homeowners insurance. There is no basis to amend or revise the substantive provisions of the proposed regulation based on the comments received.

Decision and Order

Based on the provisions of 18 **Del.C.** §§311 and 2501 et seq. and the record in this docket, I find that there is substantial evidence in favor of the adoption of this regulation to become effective on February 11, 2007.

Text and Citation

The text of the proposed amendments to Regulation 704 last appeared in the *Register of Regulations* Vol. 10, Issue 6, pages 967-968, December 1, 2006.

IT IS SO ORDERED this 5th day of January, 2007.

Matthew Denn
Insurance Commissioner

* Please note that no changes were made to the regulation as originally proposed and published in the December 2006 issue of the *Register* at page 967 (10 DE Reg. 967). Therefore, the final regulation is not being republished. Please refer to the December 2006 issue of the *Register*, page 967, or contact the Department of Insurance for more information.

A complete set of the rules and regulations for the Department of Insurance are available at:
<http://www.state.de.us/research/AdminCode/title18/index.shtml#TopOfPage>

FINAL REGULATIONS

DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Section 311 (18 Del.C. §311)
18 DE Admin. Code 1215

ORDER**1215 Recognition of Preferred Mortality Tables for use in Determining Minimum Reserve Liabilities**

After publication of proposed Regulation 1215 in the *Delaware Register of Regulations* on December 1, 2006, the public comment period on the proposed regulation remained open until January 3, 2007. Public notice of proposed Regulation 1215 in the *Register of Regulations* and two newspapers of general circulation was in conformity with Delaware law. No public comment was received by the Department of Insurance in response to the public notice.

Summary of the Evidence and Information Submitted

The purpose of this new regulation is to recognize, permit and prescribe the use of mortality tables that reflect differences in mortality between preferred and standard lives in determining minimum reserve liabilities in accordance with 18 Del.C. §§311 and 1113 and Sections 5.1 and 5.2 of Regulation 1212. The proposed regulation adopting new tables more accurately reflect differences in mortality in determining minimum reserve liabilities for certain life products. This regulation was prepared as a model regulation to promote the uniform use of such tables by the respective regulators throughout the country by the National Association of Insurance Commissioners of which Delaware is a member.

Findings of Fact

Based on the adoption of the model regulation by the National Association of Insurance Commissioners and the lack of opposition to the regulation, I find that there is substantial evidence in favor of the adoption of the regulation.

Decision and Order

Based on the provisions of 18 Del.C. §§311 and the record in this docket, I hereby adopt Regulation 1215 to be effective on February 11, 2007.

Text and Citation

The text of the proposed amendments to Regulation 1215 last appeared in the *Register of Regulations* Vol. 10, Issue 6, pages 968-970, December 1, 2006.

IT IS SO ORDERED this 5th day of January, 2007.

Matthew Denn
Insurance Commissioner

1215 Recognition of Preferred Mortality Tables for use in Determining Minimum Reserve Liabilities

(Break in Continuity of Sections)

7.0 Effective Date

7.1 The effective date of this regulation shall be ~~March 4~~ **February 11**, 2007.

* Please note that no changes were made to the regulation, except to Section 7.0, as originally proposed and published in the December 2006 issue of the *Register* at page 968 (10 DE Reg. 968). Therefore, the final regulation, in its entirety, is not being republished. Please refer to the December 2006 issue of the *Register*, page 968, or contact the Department of Insurance for more information.

A complete set of the rules and regulations for the Department of Insurance are available at:
<http://www.state.de.us/research/AdminCode/title18/index.shtml#TopOfPage>

DEPARTMENT OF INSURANCE

Statutory Authority: 18 Delaware Code, Sections 314 and 3403 (18 Del.C. §§314 & 3403)
18 DE Admin. Code 1501

ORDER

1501 Medicare Supplement Insurance Minimum Standards

After publication of proposed Regulation 1501 in the *Delaware Register of Regulations* on November 1, 2006, the public comment period on the proposed regulation remained open until January 3, 2007. Public notice of the proposed amendment to Regulation 1501 in two newspapers of general circulation was in conformity with Delaware law. Since the public notice of the proposed amendments to the regulation was not published in two newspapers of general circulation until November 30, 2006, the comment period remained open until January 3, 2007. There was one favorable comment received by the Department of Insurance from the State Council for Persons with Disabilities in response to the public notice in the *Register of Regulations* or the two newspapers of general circulation in the State of Delaware.

Summary of the Evidence and Information Submitted

Prior to the amendment effective on September 15, 2004, section 17.4.4 provided that all insurers had to make Plans A, B, C and F available in the State. The September 15, 2004 amendment contained a typographical error that resulted in the requirement that only Plan A be made available. The purpose of this amendment is to reinstate the original requirement that all insurers make Plans A, B, C and F available in the State. The State Council for Persons with Disabilities was in favor of the proposed change because of its favorable impact on Delaware consumers.

Findings of Fact

The purpose for this amendment is to reinstate the original requirement that all insurers make Plans A, B, C and F available in the State. There were no objections to the adoption of the proposed changes to the regulation. I find that the proposed change does nothing more than reinstate a long standing requirement in Delaware and makes more choices available for consumers in this State.

Decision

Based on the provisions of 18 Del.C. §§311 and 3403, and the record in this docket, I find that there is substantial evidence in favor of the adoption of the proposed amendment to Regulation 1501 to become effective on February 11, 2007.

Text and Citation

The text of the proposed amendments to Regulation 1501 last appeared in the *Register of Regulations* Vol. 10, Issue 5, pages 802-804, November 1, 2006.

IT IS SO ORDERED this 5th day of January, 2007

Matthew Denn
Insurance Commissioner

* Please note that no changes were made to the regulation as originally proposed and published in the November 2006 issue of the *Register* at page 802 (10 DE Reg. 802). Therefore, the final regulation is not being republished. Please refer to the November 2006 issue of the *Register*, page 802, or contact the Department of Insurance for more information.

A complete set of the rules and regulations for the Department of Insurance are available at: <http://www.state.de.us/research/AdminCode/title18/index.shtml#TopOfPage>

DEPARTMENT OF JUSTICE
DIVISION OF FRAUD AND CONSUMER PROTECTION

Statutory Authority: 6 Delaware Code, Section 2432A(h) (6 Del.C., §2432A(h))

ORDER

Debt Management Services

A public hearing was held to receive comments related to the Delaware Uniform Debt Management Services Act authorized under 6 Del.C. §2432A(h). Notice was provided as required under the Administrative Proceedings Act in the *Register of Regulations* at 10 DE Reg. 804 (11/01/06) as well as in the *News Journal* and *Delaware State News* on October 26, 2006. 29 Del.C. §10115.

The Director of Consumer Protection was designated by the Attorney General to conduct the public hearing held at 10 a.m. on December 11, 2006 in the Carvel State Office Building, 6th floor, 820 N. French St., Wilmington, DE 19801.

SUMMARY OF THE EVIDENCE AND INFORMATION SUBMITTED

Written Comment:

1. **Ralph S. Lewis**, Chief Operating Officer of Able Debt Settlement, Inc. submitted a letter dated December 5, 2006 on behalf of ARCUS/ADSI.

ARCUS/ADSI has requested a stay of enforcement of any adopted rules and regulations until June 1, 2007 pending formal interpretations. Generally the following problem areas were identified:

- Operation of the Act is dominated and controlled by the regulated industry.
- Operation of the Act provides no real benefit to the State.
- Operation of the Act interferes with unintended business activities
- Operation of the Act discriminates against consumers and small business.
- Operation of the Act is anti-competitive by increasing services providers expenses.
- Operation of the Act provides no greater protection for consumers and does not:
 - Prevent creditors from applying fraudulent scoring schemes used to artificially adjust financial arrangements with consumers without regulatory review.
 - Prevent creditors from alleging "universal default" or similar language to extort money or adjust financial arrangements with consumers without justification; and does not
 - Provide an automatic-stay against civil actions or harassment by creditors, debt-collectors or their collection attorneys while consumers are enrolled in and in compliance with a debt management-settlement program; and
- Operation of the Act further discriminates and is anti-competitive by allowing one party to a contract, such as a creditor, to solicit the services of a person no subject to the arduous process required under this Act while requiring another party to the same contract, such as a

consumer, to find a services provider of essentially similar tasks willing and able to comply with the Act."

More specifically, comments were made to the following rules:

1.2.4 The commenter thought that a distinction should be made between debt management services and debt settlement services viz. a debt management company holds the clients funds used for payment of the debt and a debt settlement company does not control client funds other than service fees.

4.2.1 The commenter recommended that the audit must establish a net worth consistent with the licensing of similar business activities.

4.2.3 The commenter objects to state bonding requirements for companies with national insurance coverage.

4.2.4 The commenter objects to the approval requirements for the insurance as an unreasonable interference with business activities.

4.2.4.4 The commenter objects "to this rule subject to interpretation and compliance capabilities through their respective insurance carriers."

4.2.6 The commenter objects to this rules absent an inclusion of an industry standard and mentions four models for debt settlement services providers - qualified, objective, arrangement, and negotiated.

4.2.8 The commenter objects to "ordered educational programs."

4.2.12 The commenter objects to the license fee of \$2000 as excessive.

4.5 The commenter objects to the 10 days permitted to request a hearing and suggests 30 days.

5.3.8 The commenter objects to the renewal requirement that information is presented regarding the number of individuals who successfully complete a debt management plan without interpretation.

5.6 The commenter objects to the 10 days permitted to request a hearing and suggests 30 days.

6.2 The commenter objects to the requirement for a educational program.

7.2.3 The commenter objects to the 10 days permitted to request a hearing and suggests 30 days.

8.0 The commenter objects to the requirement that an artificial entity be represented by an attorney and suggest a "Certificate of Authority"

13.3 The commenter objects to the requirement that notice is provided to the Director of Consumer Protection when civil litigation is filed noting a potential for abuse.

13.4 The commenter objects to being required to notify the Director of Consumer Protection of changes except in the case major business activities that affect the ability of the licensee to perform under its agreements with consumers.

2. Caren Lock Hanson, Board member, The Association of Debt Settlement Companies (TASC) submitted a letter dated November 30, 2006. She offered five comments:

a. Postpone Enforcement: TASC has requested that enforcement begin September 1, 2007 so members would have sufficient time to comply with the new law.

b. Cost of Registration: TASC recommends that the license fee of \$2000 be reduced to \$500

c. Certified Counselor Program: TASC recommends expeditious processing for companies seeking approval of approved certification programs.

d. New Contracts: TASC understands that companies provided services prior to the effective date of January 17, 2007 are not required to be licensed if they enroll no new Delaware clients.

e. Insurance Requirement: TASC believes that the insurance requirement under the Delaware act should have been \$250,000.

3. Leslie Linfield, Esq. submitted comments from the Institute for Financial Literacy dated November 23, 2006. The Institute for Financial literacy is a non-profit organization whose mission is making financial literacy education available to adults. The Institute has established the Center for Financial Certification to provide professional development and training for individuals in the fields of financial counseling and education. A certification program for a Certified Personal Finance Counselor (CPFC) was submitted to the Attorney General in August, 2006 for approval under the Delaware Uniform Debt-Management Services Act and is pending. The following are comments to specific proposed rules:

4.2.7 The commenter proposes that documenting the approval of a 'certifying organization' should occur outside formal rulemaking by an authorized staff person for expediency.

4.2.7.1 The commenter notes that some certification such as by the Association of Financial Counseling and Planning Education mention in Rule 4.2.7.1 require two years of experience prior to certification. Thus an organization using that program could not produce proof of certification within 12 months. In addition, the inclusion of a named organization in the rules implies and endorsement of the organization by the Attorney General mitigating in favor of a mechanism for approval outside the formal rulemaking process.

4.2.7.2 The National Foundation for Credit Counseling requires membership to use its certification program and all members must be non-profit associations. The act includes providers who are "for profit." Including a organization by name implies endorsement by the Attorney General.

4.2.7.4 The commenter recommended a better defined criteria and time-line for re-approval. Training should include "money management, credit, debt management, basic investor education and risk management tools such as insurance." Programs should also include communication, counseling and a code of ethics.

4. **Mark Guimond**, Executive Director, submitted comments on behalf of the American Association of Debt Management Organizations (AADMO) dated December 11, 2006. AADMO is a trade organization whose members include credit counseling agencies, debt management organization, credit counselors, personal finance educators, credit and debt information educators, consumer lawyers, etc. Their comments follow:

Definitions

The Act should use either "consumer" or "individual" and not both. The term "individual" is preferred. The term should be defined to refer to "consumer debts." AADMO recommends a change to the definition of "Debt-management services", viz. "services as an intermediary between an individual and 1 or more creditors of the individual for the purpose of obtaining concessions for debts for goods or services that are used primarily for personal, family, or household purposes."

Concessions

The definition in the Act for "concessions" does not recognize that following a judgment against a debtor, the concessions may be no better than the original contract but better than the judgment.

Accreditation

The terms used in the definition and rule regarding "accreditation," e.g. "prescribed", "standard," and "industry," are ambiguous. Moreover, there is no penalty for violating an accreditation standard. Presently, the standards are self-generated guidelines published by the trade organizations. There is no applicable business standard applicable to all groups in the industry. AADMO recommends that the state adopt specified criteria for organizations to meet. Accreditation providers should be required to make application for approval to substantiate their programs and provide the certification materials, qualification of the providers, and disclosure of financial arrangements with the trade organizations. Approval should not depend on the rule making process. They do not recognize the term "BYGI" in the Rule and object to including a standard - ISO9001:2000 - as an organization. AADMO support the certification of counselors but the Rule is unnecessarily restrictive. There is no definition of the term "proctor" and it is thus ambiguous.

Counselor Certification

AADMO finds the requirements for certification unnecessarily restrictive and objects to the requirement for a proctor which is not fully defined.

Applications

The bond requirement places the requirement on a corporate entity and not a "person" that is a broadly defined term under the act.

Report of successful debt management plan completions upon license renewal.

AADMO believes that Rule 5.3.8 is insufficient to address the various possible outcomes for clients in debt management plans and identify which outcomes are a "success." For example, a debtor may, during the course of a debt management plan, be able to leave the plan and resume the regular payments to a creditor. Debt management service requirements

AADMO objects to the requirement for a written disclosure in Rule 6.2.2. A record of a disclosure rather than one "in writing" should be sufficient.

5. **Jenna Keehnen**, Executive Director, submitted comments for the United States Organizations for

Bankruptcy Alternatives (USOBA) dated December 10, 2006.

Ms. Keehnen raised concerns with specific rules and offered alternative language. She suggested that since debt settlement companies do not hold client funds, the Rule 4.2.1 should be modified as follows:

4.2.1 "In the event that an applicant company holds client funds in trust for the purpose of distribution to creditors, an audited review by a certified accountant of the applicant's financial statements for the two years preceding the application or the period of existence, whichever is less."

The balance of a trust account is not a reasonable measure for the bond in 4.2.3.1 since debt settlement companies do not hold or distribute client funds. She suggested instead,

4.2.3.1 "The amount of the bond may be required to be increased after consideration of the value of the applicant's business in Delaware and the balance of the trust account, in the event that the applicant does not hold or distribute client funds, a lowered bond amount may be approved with the consent of the Attorney General."

Since the debt settlement companies do not hold the clients' funds, she suggested that Rule 4.2.5 should state:

4.2.5 "Identification of trust accounts and an irrevocable consent permitting the Attorney General and/or the designee(s) of the Attorney General to review and examine accounts along with an overdraft notification agreement, if applicant does not hold client funds or distribute funds to creditors they are exempted from this requirement."

Generally, she recommended not including approved accrediting organizations or certification programs in the body of the rule but rather by informal listing on the web page as follows:

4.2.6 "Evidence of accreditation by an independent accrediting organization approved by the Director of the Consumer Protection Unit of the Attorney General's Office that assures compliance with industry standards. A list of organizations that have been approved can be found on the website provided in 3.1.2 or a request can be sent in writing to the address provided in 3.1.1."

4.2.7 "Documentation of counselor certifications or a statement that a counselor will become certified within 12 months of employment. Certification shall be by a bona fide third-party provider approved by the Director of the Consumer Protection Unit of the Attorney General's Office. A list of organizations that have been approved can be found on the website provided in 3.1.2 or a request can be sent in writing to the address provided in 3.1.1."

Because debt settlement companies do not hold and distribute funds, the following changes were recommended for proposed Rules 5.3.4., 12.1.1, and 12.1.2:

5.3.4 "In the event that applicant company holds client funds in trust for the purpose of distribution to creditors, an audited review by a certified accountant of the applicant's financial statements for the two years preceding the application or period of existence, whichever is less."

12.1.1 "A file for each consumer containing the preliminary financial analysis prepared for the consumer, the original agreement, the consumer's total income along with the debt balance, copies of the periodic statements provided to the consumer, and if applicable: the monthly payment due each creditor."

12.1.2 "A. If applicant enrolls clients into debt management plans (DMP) an activity record for each consumer including the account number, name, address, date of the agreement, total indebtedness, monthly receipts including the date of receipt, any fees charged, amounts disbursed to creditors including the payment date, and the estimated term of the agreement. The record shall also include any action taken to recover unpaid fees that may be owed by a consumer who has cancelled an agreement.

B. If applicant enrolls clients into a debt settlement program T-whereby applicant does not hold client funds and does not distribute funds to creditors, the applicant does not hold client funds and does not distribute funds to creditors, the applicant will provide an activity record for each consumer including the account number, name, address, date of the agreement, total indebtedness, any fees charged and the estimated term of the agreement. The record shall also include any action taken to recover unpaid fees that may be owed by a consumer who has cancelled an agreement."

6. Ivan L. Hand, Jr., President and CEO of Money Management International (MMI) submitted comment in a letter dated December 8, 2006. MMI is the largest credit counseling organization in the country and maintains 135 in-person counseling offices in 22 states. It is accredited by the Council on Accreditation and taken leadership roles in the National Foundation for Credit Counseling and the Association of Independent Credit Counseling Agencies. The following changes are recommended for the reasons given:

A. Exemptions

2.1.1 ...receives no compensation from the individual receiving services ~~or a creditor of that individual.~~

Creditors are moving away from "fair share" contributions and instead offering grants. As long as the consumers are not paying a fee, the purpose of the act is served by exempting providers who are compensated by creditors.

2.3 "The Delaware Uniform Debt Management Services Act and these regulations do not apply to agreements entered into with Delaware residents prior to the effective date so long as residents have the option to terminate those agreement."

B. General Application and Renewal Requirements

4.1.13 [sic] "Identification of every state in which, during the five years immediately preceding the application, the applicant has provided debt management services to the states' residents."

Asking about where an applicant has done business will help a reviewer understand the business structure. Using the word 'state' is better understood than 'jurisdiction.'

4.1.14 [sic] "the names and addresses of all employers of each non-volunteer director during the 10 years immediately preceding the application."

The volunteer Board members should not be burdened with this requirement.

4.1.15 [sic] "the process(es) by which individuals and the applicant will inform each other within a reasonable period of time if they have knowledge that a creditor rejects or withdraws from an individual's plan."

Both the client and provider should have an obligation to communicate changes to each other.

4.2.6.3 Delete The correct organization may have been BVQi, Inc. It's process, ISO:9001 is listed.

4.2.12 ...in the amount of ~~\$2000~~ \$1000.

5.3.1 ...fee of ~~\$1000~~ \$500.

The current fees are excessive compared to other states and may discourage quality CCO's from assisting Delaware residents.

4.3.1 will make a preliminary decision on a completed application within ~~420~~ 90 days unless additional information is needed. In that case, the period is extended by ~~60~~ 45 days.

Three months is an adequate time to review an application.

5.3.6 A ~~statement~~ detailed accounting disclosing the total amount of money received on behalf of each individual debtor who resides in this State to pay creditors, ~~and including for each individual debtor~~ the amount distributed to each creditor in the 12 months immediately preceding the renewal application, if any.

5.3.7 ~~The gross amount of A summary accounting of the.....~~

These changes clarify the requirement.

C. Criminal Records Checks

The finger printing requirement for the records check is burdensome and difficult. Rules 4.2.2, 4.2.2.1, and 4.2.2.4 should delete any reference to the fingerprint requirement.

D. Bonding and Insurance Requirements

4.2.3 ...~~\$50,000~~ \$25,000...

4.2.3.1 ...The amount of the bond may be ~~required to be increased-~~ decreased...

4.2.4 ...~~\$500,000~~ \$50,000 ...

4.2.4.2 ...no greater that ~~\$5000~~ 5% of the applicant's net worth according to its audited financial statements for the previous year.

4.2.4.3 ...applicant without the approval of providing prior notification to...

5.3.5 Evidence of insurance in an amount equal to ~~the larger of \$250,000~~ \$50,000 ~~or the highest daily balance in the required trust account with terms consistent 6 Del.C. 2411A §(b)(5).~~

The bond and insurance levels are excessive for a small state and may not be affordable for some CCO's. It may be difficult to obtain a policy with a \$5000 deductible provision.

A deductible no greater than twenty times the net worth of the CCO should protect against a company being unable to pay the deductible. Moreover, it may be difficult to obtain a policy that cannot be cancelled by the license without the approval of the Consumer Protection Unit.

E. Disclosures

Generally, the disclosure requirements are repetitive and may discourage consumers. The following language is offered:

4.2.13 "Evidence demonstrating when and how the applicant informs individuals about the benefits and potential negative consequences of the Plans."

Rule 6.1 should be revised to be specific to debt management services since many providers offer other unregulated services such as personal crisis counseling, bankruptcy counseling, etc.

6.1 "Before entering into an agreement for debt management services, a licensee must provide an itemized list of debt management goods and services in the debt management agreement for services, which will be executed prior to providing debt management services and which will disclose all applicable fees as required under 6 Del.C. §2417A."

Internet access will allow a client to easily review the financial analysis and plan and is enabled with the following change:

6.2.1 "given provided access to a copy of the financial analysis and plan."

A separate record of disclosures is burdensome. The purpose of the statute is served if the information is contained in the agreement. The following change is recommended.

6.2.4 "given the separate disclosures required under 6 Del.C. §2417A(d) in writing in the debt management agreement prior to the execution of such agreement."

New language is proposed for inclusion in Rule 6.3 since the providers are not always informed of creditor concessions and concessions may be lost if payments are missed.

6.3 "Agreements must include the following provisions required under 6 Del.C. §2419A: the services to be provided; the amount, or method of determining the amount, of all fees, individually itemized, to be paid by the individual; the schedule of payments to be made by or on behalf of the individual, including the amount of each payment, the date on which each payment is due, and an estimate of the date of the final payment; if a plan provides for regular periodic payments to creditors, each creditor of the individual to which payment will be made, and the amount owed to each creditor; that the individual may cancel the agreement; that the individual may contact the Director with any questions or complaints regarding the provider; and the address, telephone number, and Internet address or website of the Director."

The format of the 'Right to Cancel' notification should allow for flexibility by revising Rule 6.3.1.

6.3.1 "Agreements must be accompanied by the 'Notice of Right to Cancel' in bold-face type surrounded by a bold black line as required under 6 Del.C. §2420A or other prominent disclosure explaining the client's right to cancel the agreement."

Providers should be permitted to charge a fee for plan enrollment since creditor 'fair share' payments are decreasing. A new Rule 6.4 could provide:

6.4 "Applicants may charge a fee not exceeding \$100 for consultation, obtaining a credit report, setting up an account, or the like."

F. Complaints

The CCO's want assurance that they will be notified as soon as possible when a consumer complaint is received by the Consumer Protection Unit and propose the following revisions to Rules 7.2.1 and 7.2.2.

7.2.1 "If, after review and/or investigation, including seeking input from the licensee who is the subject of the complaint, there is insufficient evidence to support a finding the licensee is in violation of the Debt Managements Services Act or the lawful rules promulgated under the Act, the Director may ~~sua sponte~~ dismiss the complaint on his or her accord."

7.2.2 "If, after review and/or investigation, including seeking input from the licensee who is the subject of the complaint, there is sufficient evidence to support a finding the license is in violation of the Debt Management Services Act or the lawful rules promulgated under the Act, the Director may:"

G. Hearings and examinations

The following change is recommended to Rule 8.2 so that organizations will not be discouraged from obtaining licenses because of the legal costs associated with hearings.

8.2 "An individual may represent himself or herself in a hearing. ~~An artificial entity A~~ person who is not an individual may be represent by an officer of the person or shall be represented by an attorney authorize to practice law in Delaware."

It is recommended that examinations under Rule 12.1 be allowed "off-site." Rule 12.1.1

should be modified to allow for "evidence" of periodic statements rather than copies. The requirement that a list be "alphabetical" should be deleted from Rule 12.1.1.

H. Trust account

The predominant practice when a plan is terminated is to disburse the remainder in the trust account to creditors because it is operationally difficult to cancel the disbursement. The practice should be permitted since the money is owed to the creditor. Rule 11.4 could be revised to include the qualifier "if requested to do so." New provisions were suggested that permit clients to request that a payment date be changed by the creditor to correspond to the date payment is made on the plan so that there is one due date for all creditor payments.

11.8 "Trust account disbursements should coordinate with the due dates established by each creditor.

11.8.1 Providers may require their clients to have their creditor due dates changed to correspond with the due date for their debt management services payments in order to comply with 6 Del.C. §2422A(c)(2)(B).

11.8.2 Once a provider has received verified funds for disbursement from a client, the funds should be disbursed before the next scheduled creditor due date.

I. Referrals

The regulations should permit referrals and permit fees related to the referral. Permitted referrals would not include "lead generators" of diverting consumers from one type of service provider to another for a fee. Locater services should be allowed so that servicing organizations in the credit counseling industry can connect consumers with credit counseling agencies. The recommended Rule follows.

13.5 "Payments made by or to licensees that do no more than cover the cost of informing consumers of meaningful alternatives for resolving their financial problems do not violate the Delaware Uniform Debt Management Act."

J. Advertising

A rule was proposed relating to the advertising.

13.6 "A provider, when exclusively advertising debt-management services, shall disclose in an easily comprehensible manner the information specified in §2417A(d)(3) and (4) of the Delaware Debt Management Services Act in all television, radio, and Internet advertisements."

K. Penalties, Liabilities, Defense

The exposure for liability may discourage providers from offering services in Delaware and limit options to residents. The following rules are proposed to limit exposure while providing an appropriate remedy for the consumer:

13.7 "A provider may be fined up to one thousand dollars for each violation of the Delaware Debt Management Services Act.

13.8 If an individual voids an agreement pursuant to §2425A(a), the individual may recover in a civil action the total amount of the fees, charges, money, and payments made by the individual to the provider plus interest in the amount of ten percent (10%) per year, in addition to the recovery.

13.8.1 Subject to subsection (d) §2435A(d), an individual aggrieved by a provider's intentional violation of the Delaware Debt Management Services Act may recover in a civil action from the provider and any person that caused the violation: compensatory damages for injury-cause by the violation; and reasonable attorney fees and costs.

13.8.2 If, in connection with a violation, the provider has received more money than authorized by an agreement or by this law, the defense of good faith error is not available unless the provider refunds the excess within five business days of learning of the violation."

L. Language requirements

Translating documents may be cost prohibitive for some providers especially when only a few clients use that language. The following rule is proposed:

13.9 "The disclosures and documents required by the Delaware Debt Management Services Act must be in English. If a provider communicates with an individual primarily in any language other than English, and the provider communicates with more than 25% of its new debt management clients in any given year in the other language, the provider must furnish a written translation in the other language of the disclosures and documents required by the Act."

7. Robert E. Fisher, Esq. submitted comment in a letter on December 11, 2006 at the public hearing. Mr. Fisher is senior legal counsel for Take Charge America, Inc., (TCA) a non-profit credit counseling organization incorporated in Arizona. TCA serves clients who reside in Delaware.

Like the NCCUSL model act the Uniform Delaware Debt Management Services Act is a "lengthy and complex piece of legislation" that is a "well-intentioned but profoundly misguided law" that cannot be fixed by rules. Comments to specific rules are summarized as follows:

1.1 The reference to the statutory definitions omitted "State."

1.2.4 A definition for Debt Management Services exists in the Act and should not be expanded in the rules. Debt management services does not include debt settlement and to equate them is an inherent flaw in the model law.

1.2.5 The rule contains a typo and the word "Services" should be added.

4.2.2.1 Obtaining fingerprints from a local law enforcement agency is burdensome and should permit fingerprints from other providers of fingerprint services but permitting the Attorney General to reject unsatisfactory fingerprint cards.

4.2.2.1 The amount of the mandatory minimum bond is not rational and unduly burdens interstate commerce. This is a departure from the model act from NCCUSL that permits a bond to go down. The factors to be consider in the bond such as the business or trust balance should be tailored to the Delaware clients.

4.2.4 The amount of insurance is unduly burdensome and is unrelated to important factors such as size or number of Delaware clients. The mandatory minimum is not rational and unduly burdens interstate commerce. No agency can meet this requirement in 50 states.

4.2.5 The overdraft notification agreement that is modeled after the requirement for Delaware lawyers. It is unlikely that non-Delaware banks will enter into these agreements with their depositors.

4.2.6 The ISO 9001:2000 is standard and not an organization. There is a typo in 4.2.6.3 which probably should have said Bureau Veritas Quality International (BVQI) which is now known as Bureau Veritas Certification (BVC).

4.2.7 The National Foundation for Credit Counseling (NFCC) is not a "third party provider" of counselor certification. It is an association of credit counseling organizations. Documentation should be permitted by a single document identifying the type of certification and the names of the certified counselors and not copies of all the certificates of the counselors.

4.2.3.4 is a typo that should read "4.2.7.4."

5.3.5 The insurance required on renewal has the same defects as the insurance required for initial licensure. The rule should make it clear that the amount is based on balances for Delaware clients.

5.3.6 The rules should take into consideration the privacy interests of its residents.

11.6 The overdraft notification issue was raised in 4.2.5.

12.1.1 The requirement for a "written agreement" should be clarified to include electronic agreements. Electronic and scanned documents should be permitted as the required file.

12.2 The provision allowing the examination of "[a]ny person who is connected with or associated with the licensee" is vague and overbroad. It permits the questioning un-limited non-Delaware residents.

Verbal Comment:

1. Robert L. Byrd of Wood-Byrd and Associates on behalf of TASC had two primary comments to supplement the written comment from TASC. He described some of the history of the bill and recommended changes. Specifically, he stated that there was an omission and the bill should have been amended to provide for \$250,000 in initial insurance coverage and not \$500,000. The renewal level is \$250,000. He further stated that the \$2000 application fee was negotiated with the Bank Commissioner when it was thought that he would administer the bill. Mr. Byrd thinks that number should be renegotiated to a lower level.

2. Robert E. Fisher, Esq. spoke on behalf of Take Charge America, Inc. His client is based in Phoenix, AZ and has approximately thirty state licenses. He pointed out that the credit counseling business model is very different than debt settlement and the industries should not be regulated by the same law. The drafters at NCCUSL were not familiar with credit counseling and this Act will require providers to rework business models. The statute that was passed micromanages licensees resulting in a substantial exposure for non-compliance. He saw problems in the broad definitions of "affiliates" and the restrictions on the composition of the Board of the non-profits. He noted that in the disclosures, the licensee is required to make a false statement because participation in

a debt management plan has no impact on a client's credit score. The automatic termination of a power of attorney at the time an agreement is terminated prevents the licensee from communicating important information, such as the reason for the termination of the plan, to the creditor when it is important. Finally, the private enforcement could lead to opportunistic class action litigation. He noted that only one of 40,000 clients of Take Charge, America filed a lawsuit in the last three years and lost in a summary judgment proceeding.

Mr. Fisher referred to the written comments that were submitted to address proposed regulations. The trust, insurance requirements, overdraft notification, etc. are problematic for national companies licensed in many states. It is not possible to obtain \$500,000 in insurance in each state where a provider is licensed. The Act should permit a single trust account, not one in each state and requirements should be based on trust balances. He noted that only 183 Delaware residents are in plans with Take Charge America, Inc. These are issues that could be clarified by regulation.

RECOMMENDED FINDINGS OF FACT BASED ON THE EVIDENCE AND INFORMATION SUBMITTED

Many of those submitting comments recommended changes that are outside the scope of the authority for rulemaking. Rules must implement the law and not change it. Only the General Assembly can amend the law.

Because the law becomes effective on January 17, 2007, it is important to enact rules that will at least provide an administrative hearing procedure for challenges to licensing decisions. The Attorney General is empowered to enact rules on January 17, 2007. Any substantive changes to the proposed rules will require republication as provide under 29 **Del.C.** §10118(c). In order to avoid any delay in implementation, it is recommended that only non-substantive changes to the proposed rules be considered at this time. Substantive changes and/or changes based on any legislative revisions should be revisited after June, 2007 with a new proposal that can address issues such a differentiating between debt management and debt settlement companies in the trust provisions and the documentation produced for examinations.

The following are findings based on the specific comments received.

1. Findings based on the comments of **Ralph S. Lewis for ARCUS/ADSI:**

With regard to the request for a stay of enforcement, implementation and enforcement of the law is determined by the General Assembly and it was established at six months after the law was enacted. Any change must be made by legislation and not rulemaking. The general problems described by the operation of the act are policy matters that are not within the scope of rulemaking.

With respect to the specific rules enumerated, many essentially repeat a statutory requirement and can be changed only if the enabling statute is changed by the General Assembly. See, for example, Rules 4.2.3, 4.2.4, 4.2.4.4, 4.2.8, 4.2.12, 6.2, 13.3 and 13.4.

The request made regarding Rule 8 is beyond the scope of rulemaking or legislation. The Delaware Supreme Court regulates the practice of law including advocates appearing in administrative hearings.

Several rules speak to a 10 day period to request a hearing, viz. 4.5, 5.6, and 7.2.3.

Increasing the time to request a hearing to 20 days in these rules is consistent with administrative efficiency while providing more time for applicants or licensees to make decisions requesting administrative proceedings. Increasing the time to 20 days in the named Rules is recommended.

With respect to the remaining rules, the commenter is requesting a more explicit definition of "Debt Management Services" in 1.2.4. That is a term defined in the Act and was expanded minimally for clarification in the Rules. No further explanation in the Rules to describe business practices in the industry is necessary. The detail requested in Rule 4.2.1 to establish a minimum net worth for a company is a qualification for doing business that should be established by the General Assembly if appropriate. Under the statutory scheme, it is the bond and insurance that provides protection to the consumer. Defining particular industry standards in Rule 4.2.6 may be too constraining and an applicant ought to have the flexibility to argue industry standards if there is a dispute over qualifying accreditation. Finally, under 5.3.8, the number of clients completing a program is relevant to an evaluation of a licensee. A licensee can always include an explanation if it believes the completion numbers do not offer an accurate measure of the quality of its service.

2. Findings based on the comments of **Caren Lock Hanson on behalf of TASC:**

a. The implementation and enforcement of the law is determined by the General Assembly and it was established at six months after the law was enacted. Any change must be made by legislation and not rulemaking.

b. The fee was set in the law and can only be changed by the General Assembly. The rules

for approving counselors permit flexibility. Programs will be reviewed in the order that they are received.

c. Any entity that is lawfully providing debt management services under contracts entered prior to the implementation date of January 17, 2007 can complete the contracts without becoming licensed as provided in the transitional provisions of the Act which are found in Section 3 to HB 430.

d. The insurance requirement is part of the Act and cannot be changed by rule. It appears that the insurance and bond amounts were doubled in the Delaware Act as first introduced when compared to the Uniform Act as drafted by The National Conference of Commissioners on Uniform State Laws. House Amendment 4 to House Bill 430 of the 143rd General Assembly reduced all insurance and bond amounts with the exception of the insurance required for initial licensing to the level recommended by NCCUSL.

3. Findings based on the comments by Leslie Linfield, Esq. for the Institute for Financial Literacy:

The commenter makes a good point that the approval of 'certifying organizations' should be made without the constraints of rule-making. The specificity in Rule 4.2.7 presently is a reflection of the practice in sister states who have experience licensing debt management providers. The fact that some programs are available to only non-profit members (comment to Rule 4.2.7.2) does not preclude their approval. Other programs are available for the 'for-profits.'

The documentation of certification within twelve months of employment is a statutory mandate. The fact that two years experience is necessary for certification in some programs is not necessarily a bar to using that certification program. (comment to Rule 4.2.7.1). An individual could have acquired experience in counseling before there was a requirement for certification and present proof of certification after one year of employment for a licensed services provider. It would not be possible for a person with no experience to begin employment with a licensed debt management services provider and be certified by the Association of Financial Counseling and Planning Education at the end of twelve months.

The criteria described in the comment to Rule 4.2.7.4 may become part of the evolution of the process as we become more experienced reviewing programs that are available. Deciding what criteria are fair and appropriate will require more experience with the industry and these suggestions present a good beginning.

Finally, it is not the intention of the Attorney General to endorse programs. However, the mandate of the General Assembly requires a process of approval by the Attorney General. That process may involve a periodic review of programs. Approved programs will be published on the web site of the Attorney General on the Fraud and Consumer Protection Division page just as the names of the licensees will be published.

4. Findings based on the comments of Mark Guimond, Executive Director of AADMO:

Many of the comments can only be implemented with statutory changes. For example, the use of the terms "individual" and "consumer" or the definition of "concessions." In fact, these are suggestions that should also be presented to NCCUSL if they are to become part of the uniform law that is being introduced in multiple states. Comment 1 to Section 4 of the model act from NCCUSL notes that "The Act uses the term "individual" rather than "consumer." The purpose of this usage is to enlarge the usual meaning of "consumer" (viz., one who acquires goods or services for personal, family, or household purposes) to encompass individuals who have incurred personal debt for business purposes or in connection with farming operations."

Implementing the statutory requirement for accreditation is difficult in an industry that has different business models of debt management services; it has fallen to trade organizations especially in the debt settlement model to draft standards. It must be noted that the accreditation that is approved by the Attorney General merely recognizes that an applicant has been audited by an independent party to some stated standards which may be different with different business models. Meeting those standards does not insure licensure when the standards for licensure set in the statute are higher. The Attorney General has no mandate under the law to create standards of accreditation for the industry. The penalties under the law are for violations of the statute or rules. Losing accreditation could be grounds for non-renewal. §2434A(b)(1). The approved counselor certification programs probably ought to be documented in a document separate from the rules for efficiency. Even though the rule was drafted to permit continuous approvals, there may be a perception that a provider named in the rules has a different status that a provider who is named on a web page.

The corporate surety bond provisions are in the statute in §2413A and apply to all licensees regardless of how they may be organized.

The requirement for an agency to report the numbers of "successfully completed debt management plans" (DMPs) is self-explanatory. A provider can, but is not required to, supplement a report with information about plans that were not completed because of improved circumstances of client. The proportion of successfully completed DMPs is based on the number of individuals entering into a plan and not the individuals

who for example, were referred to a bankruptcy attorney when counseling determines that they cannot benefit from a DMP.

Finally, the recommended change to Rule 6.2.2 from "writing" to "record" is a non-substantive change that can be made to the rule.

5. Findings based on the comments of Jenna Keehnen, Executive Director of USOBA:

The suggested change that would excuse the debt settlement companies who do not hold clients funds from the required audit upon application or renewal is not in the best interest of consumers. The financial condition of the company, not just the trust account, is an important element in evaluating a license application. The change to the bond requirement for debt settlement companies would require a change to the statute in 6 Del.C. 2413A.

The suggestion that the list of approved programs or organizations that certify credit counselors be included on the website is good and will be recommended. Similarly, the accreditation approval could be transferred to the website for expediency.

(Rules 4.2.6 and 4.2.7).

The comments that make a distinction for debt settlement companies in the Rules are more substantive and will be deferred until after June, 2007. There is language in §2422A(l) that demonstrates the criteria for finding that an account is a trust account.

6. Findings based on the comments of Ivan L. Hand, Jr., President and CEO of MMI:

A. Exemptions

The suggested deletion to proposed Rule 2.1.1 would require a statutory change to §2403A(b)(2). The requested addition designated Rule 2.3 excluding agreements entered into before the effective date of the statute is unnecessary. Although not codified, HB 430 contains transitional provisions in Section 3 that provide that "Transactions entered into before this Act takes effect and the rights, duties, and interests resulting from them may be completed, terminated or enforced as required or permitted by a law amended, repealed, or modified by this Act as though the amendment, repeal, or modification had not occurred."

B. General Application and Renewal Requirements

The changes requested as 4.1.13, 4.1.14, 4.2.12, and 5.3.1 require statutory changes to §§2406A(6)(16), 2405A(b)(1), and 2411A(b)(2) and not rule revisions.

The rules relating to accreditation will be transferred as information on the website. The clerical error to BVQi will be corrected.

The time permitted by law to review decisions as provide will remain. Of course, reviews may be completed sooner than the 120 days allowed.

Changes were suggested to Rules 5.3.6 and 5.3.7 that are applicable upon renewal. These Rules may be clarified after June, 2007 and before renewal. However, it may be useful in the interim to provide the comment related to Section 11 of the Act drafted by NCCUSL that was the model for §§2411A(b)(6)(7) of the Delaware Act.

"Comment 4. Paragraph (6) requires disclosure of two items. The first is the total amount received from its customers by a provider (or its designee). This requirement does not apply to a provider that directs its customers to accumulate money on their own. The second item is the total amount distributed to creditors, and this requirement applies to all providers, whether or not they (or their designees) take possession of their customers' funds.

Comment 5. Paragraph (7) supplements paragraph (6) by requiring a provider that does not take possession of its customers' funds to disclose the gross amount its customer have accumulated. "Gross amount" means total amount accumulated without adjustment for any debits, withdrawals, or payments for fees or for satisfaction of creditors' claims. A provider that does not take possession of its customer' money may monitor the customer' accounts, either by direct access to the accounts or by requiring the customers to provide periodic copies of bank statements. If the provider does not do either of these, and therefore has no knowledge of the amounts accumulated, it need make no disclosure under paragraph (7)."

C. Criminal Records Checks

The requirements for fingerprints are statutory. Applicants for other professional licenses in Delaware are required to provide fingerprints so that an FBI criminal history is available.

D. Bonding and Insurance Requirements

The suggestions made in the comments relate to statutory requirements that cannot be changed in the rules.

E. Disclosures

The addition of proposed Rule 3.2.13 is unnecessary. The law requires a provider to have a separate record of disclosures in §2417A(d) which can be part of any examination.

The changes suggested to Rule 6.1 are unnecessary and confusing. The Rules only apply to debt management services as defined in the Act. The suggested change in wording from "given" to "provided access to" in proposed Rule 6.2.1 is not consistent with the statutory mandate in §2417A(c)(1) - "provide the individual with a copy of the analysis and plan required by subsection (b) of this section in a record...."

The requirement for separate disclosures is statutory and therefore, we cannot consider the contrary recommendation to include disclosures in an agreement by way of revising Rule 6.2.4.

The suggested change to Rule 6.3 may cause providers to rely on the Rule and not read the comprehensive provisions in §2419A. All providers should be guided by the terms of the statute when offering an agreement to an individual. The provisions in §2419A will be enforced.

The suggestion that the format of the "Notice of Right to Cancel" should be flexible and the suggestion that a set-up fee of up to \$100 should be permitted are not within the scope of the rulemaking authority and must be addressed to the General Assembly.

F. Complaints

Generally, when a complaint is received, the input of the respondent [licensee] is the first step in an investigation. However, flexibility is important and there may be reasons in the public interest that the process should move forward even if the licensee cannot be reached. The suggestion the term "*sua sponte*" should be replaced with "on his or her accord" in Rule 7.2.1 is appropriate to make the Rules more readable.

G. Hearings and Examinations

Requiring an entity to be represented by counsel or some other representative at an administrative hearing is not within the scope of authority of the Attorney General or the General Assembly. The Delaware Supreme Court governs the practice of law in Delaware. The Rule 8.2 is informational and not an exercise of rule making authority.

The inclusion of the modifier "on-site" does not exclude "off site" examinations. It is intended to implement §2432A(b)(1) that speaks to access to the place of business.

A revision to Rule 12.1.1 was suggested that would permit a provider to preserve evidence of having provided periodic statements and not copies of the statements. The evidence of having provided periodic statements is not sufficient for the Attorney General to determine compliance with the statute. The content of the statements is important. Similarly, the alphabetical list of names required under Rule 12.1.1 may be necessary to facilitate an examination to determine compliance with the statute.

H. Trust Account

The change requested to Rule 11.4 would require a change to §2422A(h). The recommended addition of Rule 11.8 is unnecessary since §2422A(c)(2)(B) provides that disbursement must comply with the due dates of the creditor. The recommended requirement that clients change due dates with creditors may impose a condition that is out of the control of the client and will not be included as a rule. Finally, the scheduling of a disbursement is governed by §2422A(c)(2)(B) to "comply with the due dates established by each creditor." If a payment by the individual is not yet final, the provider may delay payment under §2422A(c)(2)(A). The proposed addition of Rule 11.8.2 is unnecessary.

I. Referrals

The comment provides useful information into industry practices. The definition and regulation of "referrals" may be an important addition to the rules. The recommendation is a substantive change that will be considered at the next opportunity after June, 2007.

J. Advertising

The comment to the act developed by NCCUSL will provide enforcement guidance. It may be appropriate to incorporate the provisions in the NCCUSL comment into the rules when they are reviewed for substantive change after June, 2007. Comment 1 to Section 30 states:

"1. This section applies to advertising in any medium, be it print, broadcast, telecast, electronic, or other. But a mere listing in a directory, such as the Yellow Pages, is not an advertisement if the entry consists solely of the name, address, and phone number of a provider. If it goes beyond this, however, the entry is an advertisement that must comply with this section."

K. Penalties, Liabilities, Defense

The recommended changes are inconsistent with the Delaware Uniform Debt Management Services Act and any amendments must be to the law by the General Assembly.

L. Language Requirements

The change requested in the comment is within the scope of the authority of the Attorney General by the terms of the Act. It is a substantive change that will be considered after June, 2007.

7. Findings based on the comments of Robert Fisher, Esq. for Take Charge America, Inc.:

The overarching concerns with the scope and depth of regulation in the Act that regulates both credit counseling and debt settlement cannot be addressed through regulation. It is a matter for the General Assembly. Findings with respect to specific rules follow:

1.1 "State" should have been included and the rule will be corrected.

1.2.4 Ordinarily, the definitions in the statute are sufficient to speak to the use of the terminology as used in the Act. The additional language in the rule definition was not intended to equate debt management and debt settlement but rather clarify that both are included in the definition of Debt Management Services and therefore regulated under the Act.

1.2.5 The typo will be corrected.

4.2.2.1 Obtaining fingerprints from law enforcement agencies insures confidence in the fingerprints that we provide to the FBI. The Attorney General is not willing to give up that measure of quality control by accepting fingerprints from unknown providers in other jurisdictions.

4.2.3.1 The parameters used to set the bond in §2413A(a)(1)(2) are for consideration by the Attorney General and the rule can state that the Attorney General will consider only the trust accounts attributable to Delaware residents. The floor remains statutory at \$50,000 for the bond or the alternative irrevocable letter of credit in §2414A.

4.2.4 The rules cannot change the insurance requirement provided in the statute.

4.2.5 The rules cannot change the statutory requirement for an overdraft notification agreement that is in the Delaware Act and not the NCCUSL model. In order to mitigate the impediment that has been reported by applicants, an agreement form is being provided on the web page that may be acceptable to the banks.

4.2.6 There was a typo in the proposal. Based on all of the comment, the accrediting organizations will not be part of the rules. The accreditation of each applicant will be evaluated until more information becomes available on the web page.

4.2.7 Information on counselor certification will be maintain on the web page rather than in the rules. Documentation is permitted by a log of counselors and certifications.

4.2.3.5 will be changed to read "4.2.7.4."

5.3.5 The rule will be clarified so that the balance of the trust account means the funds attributable to Delaware residents. The insurance levels are statutory -- the larger of \$250,000 or the trust balance. The trust balance is established with reference to §2422A and by implication means accounts established for individuals protected under the Uniform Delaware Debt Management Services Act and not the laws of other state.

5.3.6 The financial information specific to a client that is elicited in the renewal process is not considered public information under the Freedom of Information Act in 29 **Del.C.** Chapter 100.

11.6 See 4.2.5 above.

12.1.1 Electronic communication and agreements are permitted in 6 **Del.C.** §2418A. The rules do not change the statutory provisions.

12.2 The investigation and examination of licensees necessarily involves non-residents since providers of debt-management services are usually based in another state. The terms "connected or associated with the licensee" are not too vague and suggest some nexus with the licensee authorized to provide services in Delaware.

8. Findings based on the comments of Robert L. Byrd of Wood-Byrd & Associates, on behalf of TASC.

The comments regarding the license fee and the insurance requirement both speak to changes that require legislative action and cannot by change by rule. There have been other comments directed to the amount of the fee. It should be noted that although some states may have a lower fee for licenses under their debt management acts, other states may have higher fees. For example, the licensure fee in Montana is \$5000.

RECOMMENDED ACTION

After considering the provisions in the Delaware Uniform Debt Management Services Act and the comments received, it is the recommendation of the Director of Consumer Protection that the Attorney General

make the proposed findings and adopt the proposed rules as published pursuant to his authority in 6 **Del.C.** §2432(h) with the following non-substantive changes:

1.1 Insert the term ["**State**"] after the term "Sign" and before the term "Trust account."

1.2.5 "Delaware Uniform Debt Management [**Services**] Act or "Act" means the provisions in Chapter 24A of Title of the **Delaware Code**.

4.2.6 Evidence of accreditation by an independent accrediting organization approved by the Director of the Consumer Protection Unit of the Attorney General's Office that assures compliance with industry standards. A list of organizations that have been approved can be found on the website provided in Rule 3.1.2 or obtained by contacting the Consumer Protection Unit. ~~The following organizations have been approved (6 **Del.C.** §2406A(9)):~~

4.2.6.1 ISO 9001:2000

4.2.6.2 BSI Management

4.2.6.3 BYGI

4.2.6.4 ~~Council on Accreditation for Children and Families.~~

4.2.7 Documentation of counselor certifications or a statement that a counselor will become certified within 12 months of employment. Certification shall be by a bona fide third-party provider approved by the Director of the Consumer Protection Unit of the Attorney General's Office. Documentation can be in a log or other record of counselors, their certifications, and dates of certification. A list of organizations or programs that have been approved can be found on the website provided in Rule 3.1.2 or obtained by contacting the Consumer Protection Unit.

such as:-

4.2.7.1 ~~the Association for Financial Counseling and Planning Education~~

4.2.7.2 ~~the National Foundation for Credit Counseling~~

4.2.7.3 ~~a college accredited by one of the six regional accreditation services. The requirement for certification is satisfied with a course worth at least 3 semester credits, or its equivalent, covering credit counseling or debt management.~~

4.2.3.4 ~~a provider offering a training program that is approved after the curriculum is submitted to the Director of Consumer Protection for review. The program will, at a minimum, include a final examination that is administered by a proctor who verifies the identification of the person taking the test. 6 **Del.C.** §2406A(10).~~

4.5 An applicant may request a hearing within ~~40~~ twenty (20) days after receipt of the preliminary decision to deny the application.

5.3.5 Evidence of insurance in an amount equal to the larger of \$250,000 or the highest daily balance in the required trust account with terms consistent with 6 **Del.C.** §2411A(b)(5), [See Rule 3.2.3.1 through 4.2.4.4]. The balance refers to the balance attributable to clients in Delaware whose money is deposited in the trust account.

5.6 An applicant may make a request for a hearing within ~~40~~ twenty (20) days after receipt of a preliminary decision to deny the renewal application pursuant to Subchapter IV of the Administrative Procedures Act. If no hearing is requested, the preliminary decision is final.

6.2.2 inform in ~~writing~~ a record of the availability, at the consumer's option, of assistance by toll-free communication or in person to discuss the financial analysis.

7.2.1 If, after review and/or investigation, there is insufficient evidence to support a finding the licensee is in violation of the Debt Management Services Act or the lawful rules promulgated under Act, the Director may ~~sua sponte~~ on his or her own accord dismiss the complaint.

7.2.3 A licensee has ~~40~~ twenty (20) days from the receipt of a preliminary order in which to request a hearing before a hearing officer.

Because many recommendations for change received as public comment require statutory amendment, I suggest sending a copy of this order to the sponsors of the Act for their information. It may also be appropriate to review these Rules after June, 2007 to incorporate substantive changes in a new proposal after acquiring some experience in the implementation and especially if there are amendments to the statute.

DEPARTMENT OF JUSTICE

Barbara J. Gadbois, Director of Consumer Protection

ORDER AND EFFECTIVE DATE

After review of the law and comment as well as the recommendation of the Director of Consumer Protection, I hereby adopt the recommended findings of facts and the Rules as proposed in 10 DE Reg. 804 (11/01/06) and amended herein to be effective 10 days after publication of this final order in the *Register of Regulations*. The text incorporating the revisions to Rules 1.1, 1.2.5, 4.2.6, 4.2.7, 4.5, 5.3.5, 5.6, 6.2.2, 7.2.1, and 7.2.3 which are non-substantive, is attached as Exhibit A.

DEPARTMENT OF JUSTICE

Joseph R. Biden III, Attorney General

Dated: January 17, 2007

Debt Management Services**1.0 Definitions**

1.1 The following terms are defined in 6 Del.C. §2402A and have the same meaning when used in these rules.

"affiliate""agreement""bank""business address""certified counselor""Attorney General""Concessions""Day""Debt-management services""Entity""Good faith""Person""Plan""Principal amount of debt""Provider""Record""Settlement fee""Sign"["State"]"Trust account"

1.2 The following terms used herein mean:

1.2.1 "Accreditation" means certified as meeting a prescribed standard.

1.2.2 "Administrative Procedures Act" or "APA" means 29 Del.C. Chapter 101.

1.2.3 "Consumer Protection Unit" or "Consumer Protection Division" means the section of the Department of Justice established under 29 Del.C. §2517.

1.2.4 "Debt Management Services" as defined in 6 Del.C. §2402(9) include, but are not limited to, debt negotiation and settlement.

1.2.5 "Delaware Uniform Debt Management [Services] Act" or "Act" means the provisions in Chapter 24A of Title 6 of the Delaware Code.

1.2.6 "Director" means the Deputy Attorney General assigned as head of the Consumer Protection Unit.

1.2.7 "Hearing Officer" means an attorney assigned to conduct an administrative hearing.

2.0 Applicability

2.1 A provider of debt management services is not required to be licensed under the Delaware Uniform Debt Management Services Act if the provider:

2.1.1 has no reason to know the individual receiving services by agreement resides in

Delaware; or

2.1.2 receives no compensation from the individual receiving services or a creditor of that individual.

2.2 Debt management services do not include:

2.2.1 legal services provided by an attorney authorized to practice law in Delaware and in an attorney-client relationship or

2.2.2 accounting services provided by a certified public accountant licensed to provide accounting services in Delaware and in an accountant-client relationship.

2.2.3 services provided within the scope of the business or profession by

2.2.3.1 a judicial officer; or person acting under court or administrative order;

2.2.3.2 an assignee for the benefit of creditors;

2.2.3.3 a bank or government regulated bank affiliate;

2.2.3.4 a title insurer, an escrow company, or a person providing bill paying services if the provision of debt-management services is incidental to the bill-paying services.

3.0 Administration

3.1 The Consumer Protection Unit of the Fraud and Consumer Protection Division is designated by the Attorney General to administer the Delaware Uniform Debt-Management Services Act in Chapter 24A of Title 6 of the **Delaware Code**.

3.1.1 The address of the Consumer Protection Unit is 820 N. French St., Fifth Floor, Wilmington, DE 19801. The phone number is (302) 577-8600 or (800) 220-5454 (in Delaware).

3.1.2 The address for the Attorney General on the internet is <http://www.state.de.us/attgen>

3.1.3 Business hours are 8:30 to 5:00 p.m. Mondays through Fridays excluding legal State holidays as defined in 1 **Del.C.** §501.

3.2 Copies of the law and rules are available by contacting the office above or from the web site.

3.3 Applicants are required to read and comply with the law and the rules. The rules are intended to be explanatory and do not contain all of the details found in the law.

4.0 Applications

4.1 Applications for licensure shall be submitted on forms approved by the Director of the Consumer Protection Unit. Application forms will be mailed to an applicant upon request and are also available in person or through the web site at the addresses provided in Rule 3.1.

4.2 Applications must be complete before they are submitted for consideration. Incomplete applications may be denied or returned to the applicant. Applications shall include:

4.2.1 An audited review by a certified accountant of the applicant's financial statements for the two years preceding the application or the period of existence, whichever is less. 6 **Del.C.** §2406A (8).

4.2.2 At the applicant's expense, the results of a criminal history record check, including fingerprints, provided pursuant to the Federal Bureau of Investigation appropriation of Title II of Public Law 92-544 (28 U.S.C. §534) and 28 C.F.R. §50.12., conducted within the last 12 months for every officer of the applicant and every employee with access to the trust account.

4.2.2.1 The applicant may request sufficient fingerprint cards and authorization forms from the Consumer Protection Unit of the Delaware Attorney General's Office for the individuals needing criminal records checks. The cards can then be taken to a local law enforcement agency for fingerprinting. The completed cards and authorizations shall be returned to the Consumer Protection Unit for further processing by the Delaware Bureau of Identification.

4.2.2.2 The Delaware Bureau of Identification shall be the intermediary and the Office of the Attorney General of Delaware - Consumer Protection Unit shall be the screening point for the receipt of the federal criminal history records.

4.2.2.3 A license will not be denied based on the information contained in an FBI identification record until a person has a reasonable time to correct or complete the record, or has declined to do so. Procedures for obtaining a change, correction or updating an FBI identification record are set forth in 28 C.F.R. §50.12.

4.2.2.4 A criminal records check obtained for the purpose of doing business in any state, that was issued within the last 12 months and based on the fingerprints of the officer or person with access to the

trust account, satisfies this requirement if the criminal records check is provided by the licensing state and received by that state from a central repository.

4.2.3 A corporate surety bond on the form provided in an amount of at least \$50,000 from a surety company authorized to do business in Delaware (or an irrevocable letter of credit with the consent of the Attorney General) as provided in 6 Del.C. §§2405A(b)(2), 2413A, and 2414A.

4.2.3.1 The amount of the bond may be required to be increased after consideration of the value of the applicant's business in Delaware and the balance of the trust account.

4.2.3.2 The term of the bond is continuous.

4.2.3.3 The bond shall run to the State for the benefit of the Attorney General and consumers injured by any wrongful act, omission, default, fraud or misrepresentation by the applicant.

4.2.3.4 If the bond is amended, the licensee shall provide an amended copy of the original security bond to the Director of the Consumer Protection Unit of the Attorney General's Office.

4.2.3.5 No cancellation of a bond by the surety shall be effective unless written notice of an intent to cancel is filed with the Director of the Consumer Protection Unit of the Attorney General's Office at least 30 days before the effective date of cancellation.

4.2.3.6 A surety company that receives a claim against the bond shall immediately notify the Director of the Consumer Protection Unit of the Attorney General's Office. No payment shall be made without the approval of the Director of the Consumer Protection Unit of the Attorney General's Office.

4.2.4 Evidence of insurance against the risks of dishonesty, fraud, theft, and other misconduct on the part of the applicant or a director, employee, or agent of the applicant in the amount of \$500,000. 6 Del.C. §2405A(b)(4).

4.2.4.1 Insurer must be authorized to do business in the State of Delaware and be rated at least A by a nationally recognized rating organization.

4.2.4.2 The deductible shall be no greater than \$5,000.

4.2.4.3 The policy shall not be subject to cancellation by the applicant without the approval of the Director of the Consumer Protection Unit of the Attorney General's Office.

4.2.4.4 The policy shall be payable to the Applicant, the individuals having agreements with the Applicant, and the State of Delaware, as their interests may appear.

4.2.5 Identification of trust accounts and an irrevocable consent permitting the Attorney General and/or the designee(s) of the Attorney General to review and examine accounts along with an overdraft notification agreement. 6 Del.C. §§2405A(b)(3) and 2422A.

4.2.6 Evidence of accreditation by an independent accrediting organization approved by the Director of the Consumer Protection Unit of the Attorney General's Office that assures compliance with industry standards. [A list of organizations that have been approved can be found on the website provided in Rule 3.1.2 or obtained by contacting the Consumer Protection Unit. ~~The following organizations have been approved (6 Del.C. §2406A(9)):~~

~~4.2.6.1 ISO 9001:2000~~

~~4.2.6.2 BSI Management~~

~~4.2.6.3 BYGI~~

~~4.2.6.4 Council on Accreditation for Children and Families.]~~

4.2.7 Documentation of counselor certifications or a statement that a counselor will become certified within 12 months of employment. Certification shall be by a bona fide third-party provider approved by the Director of the Consumer Protection Unit of the Attorney General's Office. [Documentation can be in a log or other record of counselors, their certifications, and dates of certification. A list of organizations or programs that have been approved can be found on the website provided in Rule 3.1.2 or obtained by contacting the Consumer Protection Unit.]

[such as:

~~4.2.7.1 the Association for Financial Counseling and Planning Education~~

~~4.2.7.2 the National Foundation for Credit Counseling~~

~~4.2.7.3 a college accredited by one of the six regional accreditation services. The requirement for certification is satisfied with a course worth at least 3 semester credits, or its equivalent, covering credit counseling or debt management.~~

~~4.2.3.4 a provider offering a training program that is approved after the curriculum is submitted to the Director of Consumer Protection for review. The program will, at a minimum, include a~~

~~final examination that is administered by a proctor who verifies the identification of the person taking the test. 6 Del.C. §2406A(10).]~~

~~4.2.8 A description of the three most common educational programs provided for Delaware residents and a copy of the materials. 6 Del.C. §2406A(11).~~

~~4.2.9 A description of the financial analysis and initial budget plan including any form or electronic model used to evaluate the financial conditions of individuals. 6 Del.C. §2406A(2).~~

~~4.2.10 A copy of each form of agreement used with Delaware residents. 6 Del.C. §2406A(13).~~

~~4.2.11 A schedule of all fees, including any recommended donations, used with Delaware residents. 6 Del.C. §2406A(14).~~

~~4.2.12 The application fee in the amount of \$2000. 6 Del.C. §2405A(b)(1).~~

~~4.3 The Director of the Consumer Protection Unit:~~

~~4.3.1 will make a preliminary decision on a completed application within 120 days unless additional information is needed. In that case, the period is extended by 60 days.~~

~~4.3.2 may deny a license application for any of the reasons in 6 Del.C. §2409A(b) including:~~

~~4.3.2.1 the application contains information that is materially erroneous or incomplete;~~

~~4.3.2.2 an officer, director, or owner of the applicant has been convicted of a crime, or suffered a civil judgment, involving dishonesty or the violation of state or federal securities laws;~~

~~4.3.2.3 the applicant or any of its officers, directors, or owners has defaulted in the payment of money collected for others; or~~

~~4.3.2.4 the Attorney General, or designee, finds that the financial responsibility experience, character, or general fitness of the applicant or its owners, directors, employees, or agents does not warrant belief that the business will be operated in compliance with this chapter.~~

~~4.3.3 shall deny a license as provided in 6 Del.C. §2409A(c) if no fee accompanies the application or if the Board of Directors of a not-for-profit or tax exempt applicant is not independent of the applicant's employees and agents.~~

~~4.4 An applicant must be notified in writing of a preliminary decision to deny the application within 7 days of the decision along with the reasons for the intended action. The notification must advise the applicant of the right to a hearing.~~

~~4.5 An applicant may request a hearing within ~~10~~ **twenty (20)** days after receipt of the preliminary decision to deny the application.~~

~~4.5.1 If an applicant does not timely request a hearing, the preliminary decision is final.~~

~~4.5.2 A hearing will be scheduled upon timely request by the applicant as provided in Subchapter IV of the Administrative Procedures Act.~~

~~4.5.3 The Director, or an attorney designated by the Director, will serve as hearing officer after a preliminary decision to deny a license is made.~~

5.0 Renewals

~~5.1 Licenses shall expire one year following the date of issuance unless it is renewed as provided in 6 Del.C. §2411A.~~

~~5.2 Licensees are responsible for annual renewal whether or not a notice of renewal is received from the Consumer Protection Unit.~~

~~5.3 Renewal applications shall be on forms approved by the Director of the Consumer Protection Unit. The following shall be included with the completed renewal application form as described in the section of the Act indicated:~~

~~5.3.1 A non refundable fee of \$1000.00. 6 Del.C. 2411A §(b)(2).~~

~~5.3.2 Evidence of accreditation by an independent accrediting organization. 6 Del.C. 2411A §(b)(3).~~

~~5.3.3 Evidence of certification by applicants' counselors. 6 Del.C. 2411A §(b)(3).~~

~~5.3.4 A financial statement, audited by an accountant licensed to conduct audits, for the fiscal year immediately preceding the renewal application. 6 Del.C. §2411A(b)(3).~~

~~5.3.5 Evidence of insurance in an amount equal to the larger of \$250,000 or the highest daily balance in the required trust account with terms consistent 6 Del.C. §2411A (b)(5). [See Rule 4.2.4.1 through 4.2.4.4]. [The balance refers to the balance attributable to clients in Delaware whose money is deposited in the trust account.]~~

5.3.6 A statement disclosing the total amount of money received on behalf of each debtor who resides in this State to pay creditors, and the amount distributed to each creditor in the 12 months immediately preceding the renewal application, if any.

6 Del.C. §2411(a)(6).

5.3.7 The gross amount of money accumulated in the 12 months immediately preceding the renewal application pursuant to plans by or on behalf of individuals who reside in this State who are parties to agreements with the licensee. 6 Del.C. §2411A(a)(7).

5.3.8 A statement indicating the number of individuals who enrolled in debt management plans and the number of individuals who successfully completed debt management plans in the year preceding the renewal application.

5.4 Applications for renewal must be filed with the Director of the Consumer Protection Unit no fewer than 30 days or more than 60 days before the expiration.

5.5 If a timely and complete application for renewal is filed, a license remains in effect until the licensee is advised of a preliminary decision to deny the application along with the reasons.

5.6 An applicant may make a request for a hearing within **[10 twenty (20)]** days after receipt of a preliminary decision to deny the renewal application pursuant to Subchapter IV of the Administrative Procedures Act. If no hearing is requested, the preliminary decision is final.

5.7 If a timely and complete application for renewal is not received in the Consumer Protection Unit by the expiration date of the license, the license is expired and the former licensee is prohibited from conducting business which requires a license for Debt Management Services in this State. The applicant may apply for a new license.

6.0 Debt Management Services

6.1 Before entering into an agreement for debt management services, a licensee must provide an itemized list of goods and services and disclose all fees as required under 6 Del.C. §2417A.

6.1.1 The list must be clear and conspicuous.

6.1.2 The list must be provided in a record the consumer may retain regardless of whether an agreement is reached for services.

6.2 No debt management services may be furnished until a certified counselor conducts the education and financial analysis required, and prepare a suitable plan if appropriate, as provided in 2417A(a) and the consumer is

6.2.1 given a copy of the financial analysis and plan.

6.2.2 informed in **[writing a record]** of the availability, at the consumer's option, of assistance by toll-free communication or in person to discuss the financial analysis.

6.2.3 informed that some creditors may be unwilling to negotiate with the provider.

6.2.4 given the separate disclosures required under 6 Del.C. §2417A(d).

6.3 Agreements must include the provisions required under 6 Del.C. §2419A.

6.3.1 Agreements must be accompanied by the "Notice of Right to Cancel" in bold-face type surrounded by bold black line as required under 6 Del.C. §2420A.

6.3.2 Any agreement that does not comply with the law or rules is voidable.

6.3.3 Agreements may be terminated as provided in 6 Del.C. §2426A.

7.0 Complaints

7.1 Any person, including employees in the Consumer Protection Unit, may file a complaint against a licensee in writing on a form provided by the Consumer Protection Unit.

7.2 The Director may refer a completed and signed complaint to the Special Investigation Unit for investigation.

7.2.1 If, after review and/or investigation, there is insufficient evidence to support a finding the licensee is in violation of the Debt Management Services Act or the lawful rules promulgated under the Act, the Director may **[sua sponte on his or her own accord]** dismiss the complaint.

7.2.2 If, after review and/or investigation, there is sufficient evidence to support a finding the licensee is in violation of the Debt Management Services Act or the lawful rules promulgated under the Act, the Director may

7.2.2.1 enter a preliminary order directed to a licensee to cease and desist from any

violation, to correct a violation including providing restitution, and/or to pay a civil penalty as provided in 6 **Del.C.** §2433A;

7.2.2.2 enter a preliminary order suspending or revoking the license of licensee as provided in 6 **Del.C.** §2434A;

7.2.2.3 without entering a preliminary order, assign the matter to a Deputy Attorney General for preparation and prosecution of a formal complaint before a hearing officer;

7.2.2.4 impose civil penalties and/or recover costs of enforcement; or

7.2.2.5 proceed in any other manner permitted under the Act.

7.2.3 A licensee has [~~10~~ twenty (20)] days from receipt of a preliminary order in which to request a hearing before a hearing officer.

7.2.3.1 If no hearing is requested, the preliminary order becomes final.

7.2.3.2 If a hearing is requested, the matter will be assigned to a Deputy Attorney General as provided in 7.2.2.3.

7.2.4 When a hearing is requested following issuance of a preliminary order by the Director, enforcement is stayed pending a final determination by a hearing officer except in the case of an order issued with reference to 6 **Del.C.** §2433A(g)(2) or 2434A(c).

7.2.5 Any requested hearing will proceed as provided under the Administrative Procedures Act.

8.0 Hearings

8.1 All hearings are open to the public.

8.2 An individual may represent himself or herself in a hearing. An artificial entity shall be represented by an attorney authorized to practice law in Delaware.

8.2.1 Delaware Supreme Court Rule 72 is applicable to the admission of attorneys, who are not licensed in Delaware, *pro hac vice* before administrative agencies.

8.3 Testimony shall be under oath or affirmation.

8.4 The hearing officer shall preserve the record of the hearing including the pleadings and documentary evidence.

8.5 The hearing shall be recorded verbatim by a court reporter. The expense of preparing any transcript for any purpose, including an appeal, shall be borne by the person requesting it.

8.6 The Delaware Uniform Rules of Evidence will provide a reference for the hearing officer. However, the hearing officer may admit any evidence that reasonable and prudent individuals would commonly accept in the conduct of their affairs and give probative effect that evidence. Evidence may not be excluded solely on the ground that it is hearsay, but a decision may not be based solely on hearsay.

9.0 Summary suspension.

9.1 The Director of Consumer Protection, by designation of the Attorney General, may order a summary suspension of a license effective the date specified in the order as provided in 6 **Del.C.** §2434A (c).

10.0 Appeals

10.1 Judicial review of regulations is authorized under 29 **Del.C.** §10141.

10.2 Judicial review of case decisions is authorized under 29 **Del.C.** §10142.

10.3 There is no automatic stay of enforcement of a decision when an appeal is filed from the final order of the Director or hearing officer. The requirements for a stay of enforcement are provided in 29 **Del.C.** §10144.

11.0 Trust Account

11.1 All money provided to a licensee pursuant to a plan for distribution to creditors shall be deposited in a trust account within two (2) business days after receipt.

11.2 The licensee shall maintain separate records for each individual.

11.3 Each trust account shall be reconciled at least once each month. The balance must at all time equal the sum of the balances of each individual's account.

11.4 If the agreement is terminated or the plan fails, the licensee shall return the funds remaining in the trust account, less fees permitted under the Act, to the individual client.

11.5 A licensee shall notify the Director of the Consumer Protection Unit of the Attorney General's Office before a trust account is moved and shall provide the name, address, and telephone number of the new

bank along with the new account number.

11.6 A license must enter an overdraft notification agreement that requires the financial institution to notify the Director of the Consumer Protection Unit of the Attorney General's Office in the event that an instrument is presented for payment and the trust account contains insufficient funds, regardless of whether the instrument is honored.

11.7 A licensee shall comply with all provisions related to the trust account required by 6 Del.C. §2422A.

12.0 Examinations

12.1 An on-site examination of assets, securities, books, accounts, papers, and records of a licensee or affiliate can be conducted by an examiner designated by the Director with or without notice during regular business hours. The records shall document the information in 6 Del.C. §2427A including at least the following:

12.1.1 A file for each consumer containing the preliminary financial analysis prepared for the consumer, the original agreement, the consumer's total income along with the debt balance, the monthly payment due each creditor, and copies of the periodic statements provided to the consumer.

12.1.2 An activity record for each consumer including the account number, name, address, date of the agreement, total indebtedness, monthly receipts including the date of receipt, any fees charged, amounts disbursed to creditors including the payment date, and the estimated term of the agreement. The record shall also include any action taken to recover unpaid fees that may be owed by a consumer who has cancelled an agreement.

12.1.3 In the case of a settlement with a creditor for less than the principal amount due, the record shall include the terms of the settlement, the amount owed at the time of an agreement, the amount of the settlement, and the calculation of a settlement fee.

12.1.4 An alphabetical index of names, addresses, account numbers, date of agreement, and total indebtedness.

12.2 Any person who is connected or associated with the licensee may be examined, under oath, as to the facts and circumstances of any matter under examination.

12.3 A licensee shall pay all reasonably incurred fees, costs, and expenses directly related to an examination including travel expenses, lodging expenses, and a per diem for examiners. Payment shall be made within 10 days after receipt of a statement from the Director.

12.4 The Director may accept the report of a responsible supervisory agency from another state in lieu of an on-site examination.

13.0 Miscellaneous

13.1 Computation of time. In computing any period of time prescribed in or allowed by these Rules, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included unless it is a Saturday, Sunday or State legal holiday, in which event the period runs until the end of the next day that is not a Saturday, Sunday or State legal holiday. If service is made by mail, three days shall be added to the prescribed period for response.

13.2 A list of licensees is available upon request to the Consumer Protection Unit or online at the address in Rule 3.0.

13.3 A licensee shall notify the Director of the Consumer Protection Unit within 30 days of receipt of a notice of civil litigation filed by or on behalf of an individual who was residing in Delaware at the time an agreement for services was signed or at the time the notice was served.

13.4 A licensee shall notify the Director of the Consumer Protection Unit within 10 days after a change of information specified in 6 Del.C. §§2405A or 2406A.

**DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION****1400 Board of Electrical Examiners**

Statutory Authority: 24 Delaware Code, Section 1406(a)(1) (24Del.C. §1406(a)(1))
24 DE Admin. Code 1400

ORDER

The Board of Electrical Examiners ("Board") was established to protect the general public, specifically those persons who are the direct recipients of services regulated by 24 Del.C., Chapter 14, from unsafe practices and occupational practices which tend to reduce competition or fix the price of services rendered. The Board was further established to maintain minimum standards of practitioner competency and delivery of services to the public. The Board is authorized by 24 Del.C. §1406(a)(1) to promulgate regulations to effectuate those objectives.

Pursuant to 24 Del.C. §1406(a)(1), the Board proposed changes to its Regulations 6.0, 7.0, and 8.0 relating to electricians' liability insurance. Specifically, the changes to 6.0 License and Insurance, 7.0 Expiration and Renewal, and 8.0 Continuing Education would allow licensees to attest to maintenance of their required liability insurance during the renewal process. The Board also proposed to change 15.0 Inspection Agencies to end the Division of Professional Regulation's practice of mailing quarterly lists of licensed electricians to all licensed inspection agencies.

Pursuant to 29 Del.C. §10115, notice of the public hearing and a copy of the proposed regulatory changes was published in the *Delaware Register of Regulations*, Volume 10, Issue 4 on October 1, 2006. However, notice was not published in two (2) Delaware newspapers of general circulation, as required by 29 Del.C. §10115, so the public hearing could not be conducted on November 1, 2006 as originally scheduled. The public hearing was, therefore, rescheduled for January 3, 2007. Notice of the rescheduled public hearing was published in the *Delaware Register of Regulations*, Volume 10, Issue 6 on December 1, 2006 and in two (2) Delaware newspapers of general circulation at least 20 days prior to the rescheduled hearing.

Pursuant to such notice, the Board conducted a public hearing on January 3, 2007.

Summary of the Evidence and Information Submitted

No written or verbal comments were received.

Findings of Fact

The Board finds allowing licensees to attest to maintenance of their required liability insurance during the renewal process is necessary to make online renewal a viable option for licensees.

The Board finds that the practice of mailing quarterly lists of licensed electricians to all licensed inspection agencies is an unnecessary practice consuming scarce Division resources. The elimination of that practice will free up those resources, improving the Board's ability to carry out its statutory objectives.

Decision and Order

The Board hereby adopts the proposed amendments to the regulations to be effective 10 days following final publication of this order in the *Register of Regulations*.

Text and Citation

The text of the final regulations is attached hereto as Exhibit A and is formatted to show the amendments. A non-marked up version of the regulations as amended is attached hereto as Exhibit B.

IT IS SO ORDERED this 3rd day of January 2007 by the Board of Electrical Examiners of the State of Delaware.

BOARD OF ELECTRICAL EXAMINERS

Jacob Good, President

Richard Strouse, Vice President

Donald Collins, Secretary

Ronald Marks

C. Leroy James

James Anderson

Robert Sharp

* Please note that no changes were made to the regulation as originally proposed and published in the October 2006 issue of the *Register* at page 631 (10 DE Reg. 631). Therefore, the final regulation is not being republished. Please refer to the October 2006 issue of the *Register*, page 631, or contact the Department of State, Division of Professional Regulation, for more information.

A complete set of the rules and regulations for the Division of Professional Regulation are available at:
<http://dpr.delaware.gov/boards/electrician/index.shtml>

STATE OF DELAWARE
EXECUTIVE DEPARTMENT
DOVER

EXECUTIVE ORDER NUMBER NINETY-FOUR

RE: Declaring Tuesday, January 2, 2007 A Legal Holiday In Remembrance Of Former President Gerald R. Ford

WHEREAS, the people of Delaware have been saddened by the death of former President Gerald R. Ford, who passed away on December 26, 2006; and

WHEREAS, former President Ford leaves behind millions of people, and countless Delawareans, who wish to respectfully mourn his passing, and recognize and celebrate his extraordinary life and accomplishments; and

WHEREAS, Tuesday, January 2, 2007, has been declared a National Day of Mourning throughout the United States, and on that date there shall be a state funeral for former President Ford; and

WHEREAS, many Delawareans wish to spend the National Day of Mourning and the occasion of the former President's funeral celebrating and remembering his life, and honoring his service to our nation; and

WHEREAS, the closing of State offices in honor of former President Ford would be consistent with past actions to honor the memories of former presidents, as State offices were closed for the official state funerals of former Presidents Johnson, Eisenhower and Reagan,

NOW, THEREFORE, I, RUTH ANN MINNER, GOVERNOR OF THE STATE OF DELAWARE, DO HEREBY ORDER AND DECLARE, this 29th day of December, 2006:

1. Tuesday, January 2, 2007, is declared a State holiday pursuant to Merit Rule 5.1.1.
2. Public facilities of the State subject to my authority shall be closed Tuesday, January 2, 2007.

Approved: December 29, 2006.

Ruth Ann Minner,
Governor

ATTEST:
Harriet Smith Windsor, Secretary of State

GOVERNOR'S APPOINTMENTS

BOARD/COMMISSION OFFICE	APPOINTEE	TERM OF OFFICE
Child Protection Accountability Commission	Mr. Alvin Snyder	Pleasure of the Governor
Council on Banking	Ms. Christina M. Favilla	03/31/2008
Council on Boiler Safety	Mr. William F. Robbins	10/10/2009
Delaware Abraham Lincoln Bicentennial Commission	The Honorable Richard R. Cooch	Pleasure of the Governor
	Mr. C. Russell McCabe, II	Pleasure of the Governor
	The Honorable Richard F. Stokes	Pleasure of the Governor
	The Honorable Harriet Smith Windsor	Pleasure of the Governor
	The Honorable William L. Witham, Jr.	Pleasure of the Governor
Delaware Commission of Italian Heritage and Culture, Chair	The Honorable Richard A. DiLiberto, Jr.	12/28/2009
Delaware Science and Technology Council, Vice Chair	Mr. John O'Brien	Pleasure of the Governor
Delaware Science and Technology Council, Member	Mr. Kenneth W. Bell	Pleasure of the Governor
	Mr. J. Michael Bowman	Pleasure of the Governor
	The Honorable John C. Carney, Jr.	Pleasure of the Governor
	Ms. Uma Chowdry	Pleasure of the Governor
	Mr. Donald R. Cohee	Pleasure of the Governor
	Ms. Bette S. Coplan	Pleasure of the Governor
	The Honorable Joseph G. DiPinto	Pleasure of the Governor
	Mr. Bill Hartman	Pleasure of the Governor
	Mr. Ben Hsu	Pleasure of the Governor
Delaware Science and Technology Commission	Mr. William B. Johnson	Pleasure of the Governor

GOVERNOR'S APPOINTMENTS

1333

BOARD/COMMISSION OFFICE	APPOINTEE	TERM OF OFFICE
Delaware Science and Technology Council, Member	Mr. Matt Knight	Pleasure of the Governor
	Mr. Brian Little	Pleasure of the Governor
	Mr. Fred W. Melchior, Jr.	Pleasure of the Governor
	Mr. Jim Rand	Pleasure of the Governor
	Mr. Daniel Rich	Pleasure of the Governor
	Mr. John S. Riley	Pleasure of the Governor
	Ms. Ileana M. Smith	Pleasure of the Governor
	Ms. Carolyn A. Thoroughgood	Pleasure of the Governor
	Mr. David Weir	Pleasure of the Governor
Mr. Robert Woods	Pleasure of the Governor	
Federal Advisory Committee on Juvenile Justice, Delaware's Primary Nominee	Mr. Michael Arrington	12/31/2008
Federal Advisory Committee on Juvenile Justice, Delaware's Alternate Nominee, Juvenile Justice Advisory Group	Timothy Brandau, Ph.D	12/31/2008
	Ms. Madison J. Gerds	Pleasure of the Governor
	Ms. Erin McLaughlin	Pleasure of the Governor
Parks and Recreation Council	Mr. Joseph D. Smack	10/10/2009
Violence Against Women Act Implementation Committee	Mr. Guy H. Sapp	Pleasure of the Governor
Workforce Investment Board	Mr. John C. Castle	Pleasure of the Governor
	Mr. John A. Reed, Jr.	Pleasure of the Governor

GENERAL NOTICES

DEPARTMENT OF NATURAL RESOURCES AND ENVIRONMENTAL CONTROL DIVISION OF AIR AND WASTE MANAGEMENT

PUBLIC NOTICE

Delaware State Implementation Plan for Attainment of the 8-Hour Ozone National Ambient Air Quality Standard, Revision for Establishment of 2008 and 2009 Mobile Source Emission Budgets

This document assigns the on-road mobile source emissions budgets for each county in Delaware as part of the Philadelphia-Wilmington-Atlantic City, PA-NJ-MD-DE moderate non-attainment area for the 8 hour ozone National Ambient Air Quality Standard (NAAQ). Section 176 of the Clean Air Act (42 USC 7506) and Title 40 Parts 51 and 93 of the Code of Federal Regulations are the basis for the authority to establish mobile emission budgets in the Delaware State Implementation Plan (SIP) to attain the ozone standard. The on-road mobile source emissions budgets will be made a part of the State Implementation Plan to attain the 8 hour ozone standard by the year 2009 and to reach further reasonable progress towards attaining the standard by 2008. Therefore, the tables below will assign budgets for each year and for each county. The mobile source emissions are projected for these years using the USEPA mobile emission model, "Mobile 6.2" for calculating emission factors and the "Peninsula Travel Demand Model" for calculating future vehicle miles traveled (VMT).

Mobile 6.2 calculates emission factors for each USEPA vehicle type traveling on designated federal highway classifications road types in Delaware. Depending on the county, Delaware has up to 11 different federal highway classifications for its roads. There are two pollutants that are calculated using the mobile computer model. Volatile organic compounds (VOC) and nitrogen oxide (NOx) emission factors are generated from the Mobile 6.2 computer model. These pollutants are modeled because they are the precursors to form ground level ozone. A sample emission factor output for New Castle County for nitrogen oxides is listed below, for the projection year of 2009.

New Castle County Projected 2009 Mobile Emission Factors Nitrogen Oxides (NOx) Grams/Mile USEPA Vehicle Type*

Federal Highway Class.	LDGV	LDGT	LDGT	HDGV	LDDV			MC
	1-2	3-4			LDDT	HDDV		
Other Principal Arterial-Rural	0.51	0.37	0.42	0.38	0.19	0.23	0.22	3.35
Minor Arterial-Rural	0.54	0.39	0.44	0.42	0.20	0.25	0.25	2.75
Major Collector-Rural	0.55	0.39	0.45	0.44	0.21	0.26	0.27	2.79
Minor Collector-Rural	0.57	0.41	0.47	0.48	0.22	0.28	0.30	2.90
Local-Rural	0.83	0.60	0.70	1.08	0.37	0.51	0.66	4.21
Interstate-Urban	0.52	0.38	0.43	0.39	0.19	0.23	0.23	3.19
Other Freeway & Expressways-Urban	0.51	0.38	0.42	0.39	0.19	0.23	0.23	3.41
Other Principal Arterial-Urban	0.55	0.39	0.45	0.44	0.21	0.26	0.27	2.79
Minor	0.57	0.41	0.47	0.48	0.22	0.28	0.31	2.90
Collector-Urban	0.57	0.41	0.47	0.49	0.22	0.28	0.31	2.91
Local	0.82	0.59	0.69	1.08	0.37	0.51	0.66	4.21

*Description of vehicle types is at the end of this document

A travel demand model for the State is maintained by the Delaware Department of Transportation. The model applies a variety of data regarding roadway network conditions, vehicular travel patterns, automobile

ownership, and the location of population and employment sites. The model follows the “traditional four-step process” of trip generation, distribution, mode split, and assignment that is commonly used throughout the transportation planning industry. A similar table as above is generated for VMT according to USEPA vehicle type and federal highway classifications. The two matrices are incorporated to calculate tons per-day emissions for each pollutant.

There are numerous input criteria that go into the mobile model that affect the calculations. The major inputs are the vehicle emission control programs and clean fuel standards that are currently used or will be used for controlling and reducing vehicle emissions. They include: National Low Emission Vehicle Program and Tier 2 Motor Vehicle Controls (light duty vehicles), reformulated gas program, low sulfur gasoline program, ultra-low sulfur diesel fuel program, heavy duty engine control program beginning in 2007 reducing particulate matter and in 2010 reducing nitrogen oxides to their lowest levels. The State also has since 1983 inspected vehicles for tailpipe emissions. Currently as part of the vehicle emission inspection a vehicle on-board diagnostic system is checked for any diagnostic trouble codes which if present requires the vehicle to be repaired.

The following tables assign the on-road mobile emission budgets for milestone years of 2008 and 2009 for each county in Delaware.

2008 On-road Vehicle Mobile Emission Budgets for Delaware
(Emission in tons per day, VMT in miles per day)

Pollutant	Kent	New Castle	Sussex	DE Total
VOC	4.14	10.61	7.09	21.84
NOX	9.68	21.35	12.86	43.89
VMT	5,520,573	16,917,040	8,450,950	30,888,563

2009 On-road Vehicle Mobile Emission Budgets for Delaware
(Emission in tons per day, VMT in miles per day)

Pollutant	Kent	New Castle	Sussex	DE Total
VOC	3.95	9.89	7.05	20.89
NOX	9.04	19.23	11.93	40.2
VMT	5,703,033	17,122,179	8,541,828	31,367,040

Supporting documents, including Mobile 6.2 input, output and data files as well as spreadsheet calculation files, can be obtained by request in writing to Philip Wheeler, Air Quality Management Section, 156 South State Street, Dover, Delaware 19904 or e-mail Philip.Wheeler@state.de.us.

Description of Vehicle Types

LDGV	Light-Duty Gasoline Vehicles (Passenger Cars)
LDGT 1-2	Light-Duty Gasoline Trucks 1 (0-6,000 lbs. GVWR, 0-3,750 lbs. LVW) Light-Duty Gasoline Trucks 2 (0-6,000 lbs. GVWR, 3,751-5,750 lbs. LVW)
LDGT 3-4	Light-Duty Gasoline Trucks 3 (6,001-8,500 lbs. GVWR, 0-5,750 lbs. ALVW) Light-Duty Gasoline Trucks 4 (6,001-8,500 lbs. GVWR, 5,751 lbs. and greater ALVW)
HDGV	Heavy-Duty Gasoline Vehicles (8,501-80,000 lbs. GVWR)
LDDV	Light-Duty Diesel Vehicles (Passenger Cars)
LDDT	Light-Duty Diesel Trucks (0-8,500 lbs. GVWR)
HDDV	Heavy-Duty Diesel Vehicles (8,501-80,000 lbs. GVWR)
MC	Motorcycles

GVWR – Gross Vehicle Weight Rating

LVW – Loaded Vehicle Weight

ALVW – Adjusted Loaded Vehicle Weight

DELAWARE RIVER BASIN COMMISSION
NOTICE OF PUBLIC HEARING AND COMMISSION MEETING

The Delaware River Basin Commission will hold a public hearing and business meeting on Wednesday, February 28, 2007 at 10:15 a.m. at the Commission's offices, 25 State Police Drive, West Trenton, New Jersey. For more information visit the DRBC website at <http://www.drbc.net>, or contact Pamela M. Bush, Esq., Commission Secretary and Assistant General Counsel, at 609-883-9500 extension 203.

DEPARTMENT OF EDUCATION

The Department of Education will hold its monthly meeting on Thursday, February 15, 2007 at 9:00 a.m. in the Townsend Building, Dover, Delaware.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE
PUBLIC NOTICE
Long Term Care Medicaid

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend existing rules in the Division of Social Services Manual (DSSM) to comply with the transfer of assets provisions mandated by the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171).

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy and Program Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 (new fax number) by March 2, 2007.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE
PUBLIC NOTICE
U.S. Savings Bonds

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend a rule in the Division of Social Services Manual (DSSM) used to determine financial eligibility.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy and Program Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 (new fax number) by March 2, 2007.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

**DIVISION OF MEDICAID AND MEDICAL ASSISTANCE
PUBLIC NOTICE
DSSM 20910.1 Institutionalized Spouse**

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend a rule in the Division of Social Services Manual (DSSM) used to determine financial eligibility for medical assistance.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Policy and Program Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 (new fax number) by March 2, 2007.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

**DIVISION OF PUBLIC HEALTH
PUBLIC NOTICE**

Health Systems Management Section, under the Division of Public Health, Department of Health and Social Services (DHSS), will hold a public hearing to discuss the proposed revisions to the State of Delaware Regulations Governing the Conrad State 30/J-1 Visa Waiver Program. The public hearing will be held on February 23, 2007, at 2:00 p.m. in the Felton-Farmington Room, located in the Delaware Department of Transportation Building, 800 Bay Road, Dover, Delaware.

Copies of the proposed regulations are available for review by calling the Health Systems Management Section at (302) 741-2960.

Anyone wishing to present his or her oral comments at this hearing should contact Mr. David Walton at (302) 744-4700 by February 22, 2007. Anyone wishing to submit written comments as a supplement to or in lieu of oral testimony should submit such comments by March 2, 2007 to:

David Walton, Hearing Officer
Division of Public Health
417 Federal Street
Dover, DE 19901
Fax 302-739-6659

DEPARTMENT OF INSURANCE

**PUBLIC NOTICE OF PROPOSED CHANGES TO THE DEPARTMENT OF INSURANCE'S REGULATION
RELATING TO AUTOMOBILE INSURANCE COVERAGE**

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of a proposed change to **Regulation 608** relating to **Automobile Insurance Coverage**. The docket number for this proposed amendment is 358.

The proposed change to the regulation provides that insurers of private and commercial insurers authorized to issue private automobile insurance in this State shall provide a telephone number and email address to the Department of Insurance by and through which any insured or other claimant for benefits could contact the insurer for claims or claim related inquiries. The proposed amendment can also be viewed at the Delaware Insurance Commissioner's website at: <http://www.state.de.us/inscom/departments/documents/ProposedRegs/ProposedRegs.shtml>.

The Department of Insurance does not plan to hold a public hearing on the proposed changes. Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed amendment. Any written submission in response to this notice and relevant to the proposed change must be received by the Department of Insurance no later than 4:30 p.m., Monday, March 5, 2007, and should be addressed to Deputy Attorney General Michael J. Rich, c/o Delaware Department of Insurance, 841 Silver Lake Boulevard, Dover, DE 19904, or sent by fax to 302.739.5566 or email to michael.rich@state.de.us.

DEPARTMENT OF INSURANCE
NOTICE OF PUBLIC HEARING

PUBLIC NOTICE OF PROPOSED DEPARTMENT OF INSURANCE REGULATION RELATING TO INTERNAL REVIEW, ARBITRATION AND INDEPENDENT UTILIZATION REVIEW OF HEALTH INSURANCE CLAIMS

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of proposed amendments to Department of Insurance **Regulation 1301** relating to **Internal Review, Arbitration and Independent Utilization Review of Health Insurance Claims**. The docket number for this proposed regulation is 356.

The Department of Insurance proposes to amend Regulation 1301 by rescinding the current regulation and substituting in lieu thereof revised provisions for the review and arbitration of health insurance claims. As a result of the enactment of Senate Bill 295 on July 6, 2005 it became necessary to re-promulgate Regulation 1301 to provide for the review of claims from managed care organizations formerly under the regulatory authority of the Department of Health and Social Services. The **Delaware Code** authority for the change is 18 **Del.C.** §§311, 332 and 6401 *et seq.* The text can also be viewed at the Delaware Insurance Commissioner's website at www.delawareinsurance.gov and clicking on the link for "Proposed Regulations."

The Department of Insurance will hold a public hearing on the proposed changes on Monday, February 26, 2007 at 10:00 a.m. in the Consumer Services hearing room, 841 Silver Lake Blvd., Dover, DE 19904. Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed amendment. Any written submission in response to this notice and relevant to the proposed change must be received by the Department of Insurance no later than 4:30 p.m., March 6, 2007 by delivering said comments to Deputy Attorney General Michael J. Rich, c/o Delaware Department of Insurance, 841 Silver Lake Boulevard, Dover, DE 19904, or sent by fax to 302.739.5566 or emailed to michael.rich@state.de.us.

DEPARTMENT OF INSURANCE
NOTICE OF PUBLIC HEARING

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of proposed Department of Insurance **Regulation 1403** relating to **Managed Care Organizations**. The docket number for this proposed regulation is 357.

The Department of Insurance proposes to amend Regulation 1403 by rescinding the current regulation and substituting in lieu thereof revised provisions for the review and arbitration of health insurance claims. As a result of the enactment of Senate Bill 295 on July 6, 2005 it became necessary to re-promulgate Regulation 1301 to provide for the review of claims from managed care organizations formerly under the regulatory authority of the Department of Health and Social Services. The **Delaware Code** authority for the change is 18 **Del.C.** §§311 and 6401 *et seq.* The text can also be viewed at the Delaware Insurance Commissioner's website at www.delawareinsurance.gov and clicking on the link for "Proposed Regulations."

The Department of Insurance will hold a public hearing on the proposed changes on Monday, February 26, 2007 at 10:00 a.m. in the Consumer Services hearing room, 841 Silver Lake Blvd., Dover, DE 19904. Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed amendment. Any written submission in response to this notice and relevant to the proposed change must be received by the Department of Insurance no later than 4:30 p.m. March 6, 2007 by delivering said comments to

Deputy Attorney General Michael J. Rich, c/o Delaware Department of Insurance, 841 Silver Lake Boulevard, Dover, DE 19904, or sent by fax to 302.739.5566 or emailed to michael.rich@state.de.us.

**DEPARTMENT OF NATURAL RESOURCES AND ENVIRONMENTAL
CONTROL
DIVISION OF AIR AND WASTE MANAGEMENT
PUBLIC NOTICE**

Title of the Regulations:

Delaware Regulation Governing the Control of Air Pollution No. 1142 Section 2: Control of NOx Emissions from Industrial Boilers and Process Heaters at Petroleum Refineries.

Brief Synopsis of the Subject, Substance and Issues:

The Clean Air Act Amendments of 1990 (CAA) requires Delaware, as part of the Philadelphia-Wilmington-Atlanta City non-attainment area, to attain the 8-hour ozone National Ambient Air Quality Standard (NAAQS) by 2010. Since oxides of nitrogen (NOx) is one of the two major precursors that form ozone in the lower atmosphere, Delaware must reduce NOx emissions in order to reduce ambient ozone concentrations, to attain the NAAQS. According to the requirements of US Environmental Protection Agency (EPA), NOx reductions must be achieved by May of 2009 to ensure attainment by 2010. Delaware's emission inventory data demonstrates that large industrial boilers and process heaters in petroleum refineries in Delaware are significant NOx emitting sources. Therefore, those large boilers and process heaters should be subject to appropriate NOx emission controls.

The proposed Regulation 1142 Section 2 will affect large refinery boilers and process heaters with heat input capacities equal to or greater than 200 million British thermal units per hour (mmBTU/hour). By setting up appropriate emission rate limits and control implementation schedules for those units, NOx emission reductions will be achieved in 2009 to help Delaware attain the ozone NAAQS, and additional reduction will be achieved in 2011-2012 period to help Delaware to maintain the ozone standard once it is attained.

The proposed regulation and the associated NOx emission reductions will be included in Delaware State Implementation Plan (SIP) revisions to demonstrate Delaware's capability to make reasonable progress towards attainment, to attain the ozone standard in 2010, and to maintain the ozone standard thereafter. Those SIP revisions are due to EPA by June 2007.

In addition to aiding the adequate progress toward, and ultimate attainment of the ozone NAAQS, the proposed regulation will aid Delaware in attaining the fine particulate matter (PM) NAAQS by 2010, help satisfy Delaware's compliance with the federal Clean Air Interstate Rule (CAIR) and the federal Nitrogen Oxides Transport State Implementation Plan (SIP) Call, help satisfy EPA's finding that Delaware failed to submit a Clean Air Act Section 110 SIP addressing upwind interstate transport for the ozone and fine particulate matter NAAQS, and improve visibility.

Notice of Public Comment:

A public hearing will be held on March 6, 2007, beginning at 6:00 pm, in DNREC Conference Room A, 391 Lukens Drive, New Castle, DE 19720.

Prepared By:

Frank F. Gao, Project Leader Phone: (302) 323-4542

Date: January 11, 2007

E-Mail: Frank.Gao@state.de.us

**DIVISION OF AIR AND WASTE MANAGEMENT
Site Investigation and Restoration Branch
PUBLIC NOTICE**

Notification of Public Comment Period Regarding the Independent Study Report for the Proposed Remedy at the Hay Road Sludge Drying ("Iron Rich") Site

The Delaware Department of Natural Resources and Environmental Control ("DNREC" or the "State of Delaware") is seeking written public comments regarding the Independent Study Report, prepared by Schnabel Engineering North, LLC (Schnabel), December 20, 2006. This report addresses an independent environmental evaluation of the proposed remedy at the Hay Road Sludge Drying ("Iron Rich") Site ("Site"), pursuant to the 143rd General Assembly, House Concurrent Resolution No. 22 (HCR 22).

DNREC retained Schnabel to perform an objective and independent third-party evaluation of the proposed remedy for the Site following public solicitation for an independent contractor as stated in HCR 22. Pursuant to HCR 22, DNREC took responsibility for administering the contract, including developing the scope of work for the contractor solicitation. In addition, DNREC provided the draft scope of work to community representatives and interested members of the public who reviewed the scope of work to be addressed in the Independent Study Report prior to DNREC finalizing the contract with Schnabel.

The primary findings of the overall evaluation indicate concerns and/or deficiencies in the information and submittals relating to the (1) Dredged Material, (2) Groundwater; (3) Iron Rich Material (IRM), (4) Remedial Investigation/Risk Assessment (RI/RA), and (5) Focused Feasibility Study (FFS). The data deficiencies raise questions about the sufficiency of the technical support for the selected remedy. The study did not reach any conclusions about the adequacy of the remedy, however. For further detail, the Independent Study Report and related documents are available at DNREC's Air and Waste Management Division's web page under "DuPont Iron Rich Pile" at <http://www.dnrec.state.de.us/dnrec2000/Divisions/AWM/sirb/>

Hard copies of the report are available at the office of DNREC-SIRB, 391 Lukens Drive, New Castle, Delaware 19720 or in the Claymont and Wilmington Public libraries.

Pursuant to House Concurrent Resolution No. 22, "...the results shall become a part of the public record, open for public comment for 30 days, and shall become a part of the decision-making process of DNREC for the ultimate disposition of the material". The comment period will close @ 4:30 p.m. on Friday, March 2, 2007. Interested parties may submit their comments in writing to Qazi Salahuddin, Ph.D., Program Manager, DNREC-SIRB, 391 Lukens Drive, New Castle, Delaware 19720 or via e-mail to gazi.salahuddin@state.de.us.

**DIVISION OF FISH AND WILDLIFE
NOTICE OF PUBLIC HEARING**

The Department of Natural Resources and Environmental Control will hold a public hearing regarding a proposed amendment to Tidal Finfish Regulation 3580 concerning commercial fishing for spiny dogfish.

The proposed action is to re-open the commercial fishery in Delaware for the spiny dogfish (*Squalus acanthias*) in accordance with the latest revision of the Atlantic States Marine Fisheries Commission's Interstate Fishery Management Plan for Spiny Dogfish and in accordance with federal law, whichever is more restrictive. When federal seasons and catch limits are more restrictive than state limits or Atlantic States Marine Fisheries Commission limits, then federal limits shall apply under the proposed regulation. For federal purposes, the fishery for spiny dogfish is split into two quota periods; May 1 through October 31 and November 1 through April 30 with an annual coastal quota of 4 million pounds. The daily catch (possession limit) of spiny dogfish in federal waters is 600 lbs. per day for participants in the spiny dogfish fishery. Under this proposal, when the federal quota is reached for any quota period, the federal fishery closes. It is proposed that the State of Delaware fishery will automatically close as well when the federal quota is reached and the National Marine Fisheries Service declares the federal spiny dogfish fishery closed.

Individuals may address questions to the Fisheries Section, Division of Fish and Wildlife, 89 Kings Highway, Dover, DE 19901, or by phone to (302) 739-9914 or by e-mail to roy.miller@state.de.us. A public hearing

on this regulation will be held in the Department of Natural Resources and Environmental Control Auditorium, at the same address, at 6:30 PM on February 21, 2007. Comments for the hearing record should be addressed to Lisa Vest, Hearing Officer, Office of the Secretary, Delaware Department of Natural Resources and Environmental Control, 89 Kings Highway, Dover, De 19901 or by e-mail to Lisa.Vest@state.de.us

DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
2000 Board of Occupational Therapy
NOTICE OF PUBLIC HEARING

The Delaware Board of Occupational Therapy, in accordance with 24 **Del.C.** §2006(a)(1), has proposed changes to its Regulations 2.0 and 3.0 to change the audit process for license renewal so that continuing education attestations will be audited after the license renewal period is over, rather than before the expiration date. The changes will also extend the period of time during each biennial licensure period during which licensees may obtain required CE credits from May 31st of each renewal year to July 31st of each renewal year, to correspond with the license renewal period.

A public hearing will be held on March 7, 2007 at 4:45 p.m. in the second floor conference room B of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware, where members of the public can offer comments. Anyone wishing to receive a copy of the proposed rules and regulations may obtain a copy from the Delaware Board of Occupational Therapy, 861 Silver Lake Blvd, Cannon Building, Suite 203, Dover DE 19904. Persons wishing to submit written comments may forward these to the Board at the above address. The final date to receive written comments will be at the public hearing.

The Board will consider promulgating the proposed regulations at its regularly scheduled meeting following the public hearing.

DIVISION OF PROFESSIONAL REGULATION
2700 Board of Professional Land Surveyors
PUBLIC NOTICE

The Delaware Board of Professional Land Surveyors in accordance with 24 **Del.C.** §2706(a)(1) has proposed revisions to its rules and regulations. The proposed revisions to the Rules and Regulations are being updated to enable licensees to renew their licenses on line, attest that they have completed the required continuing education and change the period of late renewal of licenses. Documentation of having completed the required continuing education must still be maintained by the licensee but it will only be required to be produced in the event the licensee is randomly selected for continuing education audit post renewal.

A public hearing will be held on March 15, 2007 at 8:30 a.m. in the second floor conference room A of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware where members of the public can offer comments. Anyone wishing to receive a copy of the proposed rules and regulations may obtain a copy from the Delaware Board of Professional Land Surveyors, 861 Silver Lake Boulevard, Cannon Building, Suite 203, Dover, DE 19904. Persons wishing to submit written comments may forward these to the Board at the above address. The final date to receive written comments will be at the public hearing.

The Board will consider promulgating the proposed regulations at its regularly scheduled meeting following the public hearing.

**DIVISION OF PROFESSIONAL REGULATION
3500 Board of Examiners of Psychologists
PUBLIC NOTICE**

The Delaware Board of Examiners of Psychologists in accordance with 24 **Del.C.** §2604(a)(1) has proposed changes to its rules and regulations to allow for online renewal of licenses and online attestation of completion of continuing education hours. The proposed changes also provide for a post-renewal audit, so that licensees have the full two-year period to obtain required continuing education. Under the proposed rules, licensees may earn continuing education through the July 31 deadline. In addition, the proposed rules specify the number of continuing education credits required for newly-licensed individuals. The proposed rules also clarify the information that must be submitted to the Board to obtain licensure. Finally, the proposed revisions implement the recent changes to the reciprocity provisions of the Board's statute, 24 **Del.C.** §3511. These changes allow professionals that have passed the required examination and have been licensed in another state for at least two continuous years to satisfy the requirements of licensure in Delaware by submitting information showing that they hold a current Certificate of Professional Qualification in Psychology (CPQ) issued by the Association of State and Provincial Psychology Boards (ASPPB), or are currently credentialed by the National Register of Health Service Providers in Psychology.

A public hearing will be held on March 5, 2007 at 9:30 a.m. in the second floor conference room A of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware, where members of the public can offer comments. Anyone wishing to receive a copy of the proposed rules and regulations may obtain a copy from the Delaware Board of Examiners of Psychologists, 861 Silver Lake Blvd, Cannon Building, Suite 203, Dover, DE 19904. Persons wishing to submit written comments may forward these to the Board at the above address. The final date to receive written comments will be at the public hearing.

The Board will consider promulgating the proposed regulations at its regularly scheduled meeting following the public hearing.
