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# Delaware Register of Regulations

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Volume 10 - Issue 10, Pages 1471 - 1638

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Proposed

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Calendar of Events &

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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 March 15, 2007.

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# INFORMATION ABOUT THE DELAWARE REGISTER OF REGULATIONS

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The *Delaware Register* will publish any regulations that are proposed to be adopted, amended or repealed and any emergency regulations promulgated.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

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## 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.

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## 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.

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other interested parties may participate in the process by which administrative regulations are adopted, amended or repealed, and may initiate the process by which the validity and applicability of regulations is determined.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

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# INFORMATION ABOUT THE DELAWARE REGISTER OF REGULATIONS

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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*.

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## CLOSING DATES AND ISSUE DATES FOR THE DELAWARE REGISTER OF REGULATIONS

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

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## 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.)

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## 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.

F. On January 8, 2007, I issued an Emergency Order adopting revisions to Regulation 1301. As a result of public comment received in response to the proposed revisions as published in the February 1, 2007 Register of Regulations, it is necessary to rescind the order of January 8, 2007 and substitute in lieu thereof, a new Emergency Order placing into effect revisions to Regulation 1301 based on the public comment received by the Department of Insurance.

### DECISION AND ORDER

1. Regulation 1301 as currently promulgated as an emergency regulation is rescinded and the attached revised version of Regulation 1301 is substituted in lieu thereof as a new emergency regulation effective March 15, 2007.

2. This order shall be effective until July 15, 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](http://www.delawareinsurance.gov) and clicking on the link for "Proposed Regulations."

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., Wednesday, May 2, 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](mailto: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 15<sup>th</sup> day of March, 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 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

# EMERGENCY REGULATIONS

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 \_\_\_\_\_

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

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# EMERGENCY REGULATIONS

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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 \_\_\_\_\_

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 G

Proof Of Service Of Papers Required For Arbitration

# EMERGENCY REGULATIONS

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;

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# EMERGENCY REGULATIONS

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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 services to a non-network emergency care provider who was a network emergency care provider at any time prior to the date the provider delivered the emergency care services which are the subject of the arbitration. A carrier shall pay such non-network emergency care provider the higher of either (1) the highest contract rate for the services provided during the term of the provider's contract with the insurer, subject to such rate adjustments as may be published in bulletins by the Commissioner from time to time, 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.

7.3.2 Other payments for emergency care services with CPT codes. A carrier shall pay non-network emergency care providers who were never network providers with the carrier 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.

7.3.3 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.

7.3.4 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.

7.4 Duty to Arbitrate. Every carrier and provider shall submit to arbitration pursuant to this Section 7.0 all fee disputes arising from the provision of emergency care services under 18 Del.C. §3349 and 3565, except as provided in Section 5.4.

## **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

# EMERGENCY REGULATIONS

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 June 11, 2007. Pursuant to the orders of the Commissioner dated January 8, 2007 and March 15, 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.

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## **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

### **EXTENSION OF EMERGENCY ORDER**

**WHEREAS** an emergency order placing into effect proposed changes to Regulation 1403 was published on January 8, 2007; and

**WHEREAS** the said order was set to expire on April 30, 2007; and

**WHEREAS** it is necessary to provide for an extension of the emergency regulation so that revisions to the proposed regulation can be published for comment pursuant to the Delaware Administrative Procedures Act; and

**WHEREAS** it is appropriate for the Department of Insurance to allow for additional public comment on the regulation as proposed and published on January 8, 2007;

**NOW THEREFORE**, pursuant to 29 **Del.C.** §10119, Emergency Regulation 1403 as it appears in 10 **DE Reg.** 1190-1201 (2/1/07) shall be and is hereby extended until June 30, 2007 or until the proposed amendments to Regulation 1403 are adopted in final form, whichever shall first occur. 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. Wednesday, May 2, 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](mailto:michael.rich@state.de.us).

**IT IS SO ORDERED** this 14<sup>th</sup> day of March, 2007.

Matthew Denn, Insurance Commissioner

**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.

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**DEPARTMENT OF AGRICULTURE  
NUTRIENT MANAGEMENT COMMISSION**

Statutory Authority: 3 Delaware Code, Section 2221 (3 **Del.C.** §2221)  
3 **DE Admin. Code** 1201

**PUBLIC NOTICE**

Nutrient Management Certification Regulation Amendments (Exhibit A): Certification by the Delaware Nutrient Management Program, 2320 S. Dupont Hwy., Dover, DE 19901, is required (3 **Del.C.** §2201 - 2290) for all who apply fertilizer and/or animal manure greater than 10 acres or who manage animals greater than 8,000 pounds of live animal weight. The proposed changes to the certification regulations establish nutrient handling requirements for certain nutrient handlers. The proposed regulation addresses application timing and placement for commercial inorganic fertilizer and organic fertilizer

Comments on the proposed changes will be accepted from April 1, 2007 until April 30, 2007. Any comments should be provided to the Nutrient Management Program office located at 2320 S. Dupont Hwy., Dover, DE 19901, ATTN: William Rohrer.

**1201 Nutrient Management Certification Regulations****1.0 Authority**

These regulations are promulgated pursuant to the authority provided by 3 **Del.C.**, Ch. 22, §2221.

**2.0 Purpose**

The purpose of these regulations is to establish certification requirements for certain generators or handlers of nutrients, or who engage in advising or consulting with others regarding the formulation, application, or scheduling of nutrients within the State of Delaware.

**3.0 Definitions**

For purposes of these regulations, the following words or terms shall have the meanings as indicated:

“**Animal Feeding Operation**” or “**AFO**” means any area or facility where animals have been, are, or will be stabled or confined and fed or maintained for a total of 45 days or more in any 12 month period.

“**Animal Unit**” shall be as defined by the United States Department of Agriculture Natural Resources Conservation Service, and is approximately 1,000 lbs. "average" live body weight.

“**Applicant**” means any person seeking a certificate from the Commission.

“**Apply, Applying**”, or any derivation of the word "apply", as it relates to the application of nutrients, means the human controlled mechanical conveyance of nutrients to land for the purpose of applying organic and/or inorganic nutrients.

“**Certification**” means the recognition by the Commission that a person has met the qualification standards established by the Commission and has been issued a written certificate authorizing such person to perform certain functions specified in these regulations.

“**Commercial Nutrient Handler**” means a person who applies organic or inorganic nutrients to lands or waters in the State as a component of a commercial or agricultural business in exchange for a fee or service charge.

“**Commercial Processor**” means any individual, partnership, corporation, association or other business unit that controls, through contracts, vertical integration or other means, several stages of production and marketing of any agricultural commodity.

“**Commission**” or “**DNMC**” means the Delaware Nutrient Management Commission.

“**Credit**” represents a unit of measuring education for certification as defined by the Commission and is dependent upon such factors as curricula intensity and class time.

“**Direct Supervision**” refers to actions by a person who is certified with the State Nutrient Management Program and directs individuals within the same organization/company in applying nutrients. Direct supervisors hold responsibility for nutrient application actions for those under his/her supervision.

“**Fertilizer**” means any synthetic or carbon based substance that is added to the soil to supply one or more plant nutrients.

“**Frozen**” relates to frozen ground and is the top 2-inches of surface area receiving nutrients where the moisture has changed to ice for a period of 72 consecutive hours or a condition where any ice formation below the 2-inch zone restricts the natural flow of moisture through the soil profile.

“**Nutrient Consultant**” means a person who is engaged in the activities of advising or consulting with another person who is required to have a certificate under these regulations, regarding the formulation, application, or scheduling of organic or inorganic nutrients within the State. Provided, however, any employee of any federal, State or local government agency or the University of Delaware, or other organization duly recognized by the Commission for such purpose, who provides advice or consultation in his/her capacity as such an employee, without compensation, shall not be deemed to be a nutrient consultant unless such advice and consultation constitutes a direct and substantial part of a nutrient management plan developed pursuant to these regulations.

“**Nutrient Generator**” means a person who owns or operates a facility within the State that produces organic or inorganic nutrients.

“**Nutrient Management Plan**” or "plan" means a plan by a certified nutrient consultant to manage the amount, placement, timing, and application of nutrients in order to reduce nutrient loss or runoff and to maintain the productivity of soil when growing agricultural commodities and turfgrass.

“**Nutrients**” means nitrogen, nitrate, phosphorus, organic matter, and any other elements necessary for or helpful to plant growth.

“**Person**” means any individual, partnership, association, fiduciary, or corporation or any organized group of persons, whether incorporated or not.

“**Private Nutrient Handler**” means a person in the State who applies organic or inorganic nutrients to lands or waters he/she owns, leases, or otherwise controls.

“**Program Administrator**” or "Nutrient Management Program Administrator" means the exempt employee of the Delaware Department of Agriculture who is responsible for the operation of the State Nutrient Management Program.

“**Secretary**” means the Secretary of the Delaware Department of Agriculture or his/her designee.

“**State Nutrient Management Program**” or “**SNMP**” means all the nutrient management program elements developed by the Commission, whether or not reduced to rules or regulations.

## 4.0 Certification Categories And Activities Requiring Certification

4.1 No later than January 1, 2004, any person who engages in any of the following activities must have the applicable certificate or certificates required by and issued pursuant to these regulations, as follows:

4.1.1 Nutrient generator certification - A nutrient generator who owns or operates any animal feeding operation in excess of eight animal units must have a nutrient generator certificate.

4.1.2 Private nutrient handler certification - A private nutrient handler who, on an annual basis, applies nutrients to 10 acres or greater of land or waters owned, leased, or otherwise controlled by such handler must have a private nutrient handler certificate.

4.1.3 Commercial nutrient handler certification - A commercial nutrient handler who, on an annual basis, applies nutrients to 10 acres or greater of land or waters of the state must have a commercial nutrient handler certificate.

4.1.4 Nutrient consultant certification - A nutrient consultant who is engaged in the provision of nutrient management advice or the formulation of a nutrient management plan or in nutrient management planning as it relates to the application or disposal of nutrients at or from a specific site in the State of Delaware must have a nutrient consultant certificate.

4.2 These certification requirements shall not apply to individuals who perform services under the direct supervision of a certified person, provided that the certified person assures that such individuals act in accordance with the standards or practices which the certified person would follow if such person performed the service. Nor shall the certification requirements of this section apply to persons who utilize a person certified under these regulations to conduct the activities identified in this section, provided that such persons do not engage in any of the activities themselves and the certified person is certified at the time the activities are undertaken.

4.3 Conditional certifications may be issued for any reason specified by the Commission and shall be issued for periods not to exceed one year.

## **5.0 Certification Requirements**

5.1 Any person who seeks a certification shall file with the Commission an application on a form provided by the Commission, along with the application fee. The minimum requirements for the certifications follow.

5.2 Nutrient generator certificates - To obtain a nutrient generator certificate, the applicant must take and successfully complete at least 6 credits of educational course work as approved by the Commission or Program Administrator. Proof of such completion of course work shall be submitted with the application.

5.3 Private nutrient handler - To obtain a private nutrient handler certificate, the applicant must take and successfully complete at least 9 credits of educational course work as approved by the Commission or Program Administrator. Proof of such completion of course work shall be submitted with the application.

5.4 Commercial nutrient handler - To obtain a commercial nutrient handler certificate the following criteria must be satisfied:

5.4.1 The applicant must take and successfully complete at least 12 credits of educational course work as approved by the Commission or Program Administrator. Proof of such completion of course work shall be submitted with the application.

5.4.2 The applicant must pass a written test approved by the Commission.

5.5 Nutrient consultant - To obtain a nutrient consultant certificate the following criteria must be satisfied:

5.5.1 The applicant must take and successfully complete at least 12 credits of educational course work as approved by the Commission or Program Administrator. Proof of such completion of course work shall be submitted with the application.

5.5.2 The applicant must pass a written test approved by the Commission.

## **6.0 Nutrient Handling Requirements**

6.1 As required by 3 Del.C. §2201 et.al, Nitrogen and Phosphorus fertilizers shall be applied according to a Nutrient Management plan.

6.2 For land areas not required to have a Nutrient Management plan, applications of Nitrogen and Phosphorus fertilizers by anyone holding a commercial nutrient handler or nutrient consultant certification, or anyone required to be certified at said level pursuant to 3 Del.C. §2242 and section 4.0 herein, are prohibited when one of the following conditions exist:

6.2.1 The surface area of application is impervious such as sidewalks, roads and other paved areas and the misdirected fertilizer is not removed on the same day of application;

6.2.2 The surface area is covered by snow or frozen; or

6.2.3 The date of application is between December 7 and February 15.

**~~6-0~~ 7.0 Reciprocity**

~~6-1~~ 7.1 Notwithstanding the requirements of Section 5.0, supra, any person may obtain a certificate under these regulations if all the following requirements are satisfied.

~~6-2~~ 7.2 The applicant must submit an application for the applicable certificate on a form provided by the Commission, along with the application fee.

~~6-3~~ 7.3 The applicant must have a valid certificate or equivalent authorization, such as a license for the certificated activity, from another state or organization that requires qualifications at least as rigorous as those required under these regulations and approved by the Commission.

~~6-4~~ 7.4 The applicant must pass a test approved by the Commission related to specific Delaware Nutrient Management requirements. The Commission may in its sole discretion waive this test requirement.

**~~7-0~~ 8.0 Continuing Education**

~~7-1~~ 8.1 After a certificate is issued, the certificate holder must take and successfully complete continuing education courses approved by the Commission or Program Administrator in accordance with the following:

~~7-1.1~~ 8.1.1 Nutrient generator - 6 credits of continuing education in each three-year period following the issuance of the certification.

~~7-1.2~~ 8.1.2 Private nutrient handlers - 6 credits of continuing education in each three-year period following the issuance of the certification.

~~7-1.3~~ 8.1.3 Commercial nutrient handlers - 6 credits of continuing education in each three-year period following the issuance of the certification.

~~7-1.4~~ 8.1.4 Nutrient consultants - 5 credits of continuing education each year following the issuance of the certification.

~~7-2~~ 8.2 Failure to satisfy the continuing education requirements may result in the revocation of a certificate or non-renewal of the certificate.

~~7-3~~ 8.3 Any dispute regarding continuing education credits may be directed to the Commission which will determine whether a hearing is necessary to resolve the dispute.

**9 DE Reg. 966 (12/01/05)**

**~~8-0~~ 9.0 Duration Of Certificates And Certification Fees**

~~8-1~~ 9.1 Certificates normally will be issued and renewed for periods of three years for nutrient generators, private nutrient handlers, and commercial nutrient handlers. Certified nutrient consultants will be issued and renewed certifications annually.

~~8-2~~ 9.2 Certificate fees are due with the application. The fee for a one-year certificate issued to nutrient consultants shall be \$100.00. The certificate fee for commercial nutrient handlers for a three-year certificate shall be \$150.00.

~~8-3~~ 9.3 No fee will be charged for certification of a nutrient generator or a private nutrient handler.

**~~9-0~~ 10.0 Suspensions, Modifications, And Revocations**

~~9-1~~ 10.1 The Commission may, after notice and opportunity for hearing, suspend, modify, or revoke any certificate where the Commission has reasonable grounds to believe that the certificate holder is responsible for violations of the nutrient management statute (Title 3, Chapter 22, of the **Delaware Code**) or Commission regulations. The Commission shall furnish the person accused of a violation with notice of the time and place of the hearing, which notice shall be served personally or by registered mail directly to such person's place of business or last known address with postage fully paid no sooner than 10 days but within 21 days of the time fixed for the hearing.

**~~10-0~~ 11.0 Certification Renewals**

~~10-1~~ 11.1 At least 60 days before the expiration of a certificate, the certificate holder shall file an application with the Commission for renewal of the certificate, along with the certification fee.

~~10-2~~ 11.2 Nutrient consultants must file with the application and fee evidence that the consultant prepared at least one nutrient management plan during the preceding three-year period. If no such plan was prepared, the certificate shall not be renewed.

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~~40-3~~ 11.3 The certificate holders must also supply with the application and renewal fee evidence that they have complied with the continuing education and record keeping and reporting requirements contained in these regulations.

~~40-4~~ 11.4 Absent good cause for failure to timely file an application for renewal in compliance with these requirements, the certificate holder must reapply for the certificate in the same manner required for the issuance of the original certificate.

~~40-5~~ 11.5 Decisions to refuse renewal of a certificate shall be final and conclusive unless appealed to the Commission pursuant to Section 2262, Chapter 22, of the **Delaware Code**.

## ~~41-0~~ 12.0 Appeals To The Secretary

All decisions of the Commission under this regulation shall be final and conclusive unless appealed to the Secretary pursuant to Section 2263, Chapter 22, of the **Delaware Code**. Provided, however, that the denial of a certificate pursuant to Sections 2243 or 2245, Chapter 22, of the **Delaware Code** shall first be appealed to the Commission which shall hold a hearing.

## ~~42-0~~ 13.0 Record Keeping.

~~42-1~~ 13.1 Nutrient generators shall record and keep the following available for inspection by the Secretary or the Commission:

~~42-1-1~~ 13.1.1 A contemporaneously recorded log that contains the dates, approximate quantities, locations, and disposition (stored, shipped, etc.) of nutrients that are applied to land or transported from land owned, leased or otherwise controlled by the Nutrient Generator.

~~42-1-2~~ 13.1.2 A copy of any applicable nutrient management plan.

~~42-2~~ 13.2 Private nutrient handlers shall record and keep the following available for inspection by the Secretary or the Commission:

~~42-2-1~~ 13.2.1 A contemporaneously recorded log showing the dates, locations, approximate quantities, acreage and methods of nutrient application.

~~42-2-2~~ 13.2.1 A copy of any applicable nutrient management plan.

~~42-3~~ 13.3 Commercial nutrient handlers shall prepare and keep available for inspection by the Secretary or the Commission, a contemporaneously recorded log showing the dates, locations, approximate quantities, acreage, and methods of nutrient application.

~~42-4~~ 13.4 Nutrient consultants shall prepare and/or keep available for inspection by the Secretary or the Commission, copies of any written materials prepared by the nutrient consultants or at their direction that establish how nutrients are to be managed at specific sites within Delaware, such as nutrient management plans.

~~42-5~~ 13.5 The information required in this section shall be kept and maintained for a period of 6 years.

## ~~43-0~~ 14.0 Effective Date.

These regulations shall become effective on January 10, 2001

**4 DE Reg. 1117 (1/1/01)**

## DEPARTMENT OF EDUCATION

### OFFICE OF THE SECRETARY

Statutory Authority: 14 Delaware Code, Section 152 (14 **Del.C.** §152)

14 **DE Admin. Code** 505

### PUBLIC NOTICE

#### 505 High School Graduation Requirements and Diplomas

#### 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** 505 High School Graduation Requirements and Diplomas in order to update the definition of Career Pathway, to change the name and definition of the "Individual Learning Plan" to the "Student Success Plan" and in 4.0 to describe the process for implementing the Student Success Plan. A grammatical error was also corrected at the end of the Science definition.

Persons wishing to present their views regarding this matter may do so in writing by the close of business on or before Thursday, April 5, 2007 to Carol O'Neill Mayhew, Education Associate, Regulation Review, Department of Education, at 401 FEDERAL STREET, SUITE 2, DOVER, DELAWARE 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 amended regulation will help improve student achievement as measured against state achievement standards because of the academic support system for students that it puts in place.

2. Will the amended regulation help ensure that all students receive an equitable education? The amended regulation will help ensure that all students receive an equitable education through the academic support system that it puts in place.

3. Will the amended regulation help to ensure that all students' health and safety are adequately protected? The amended regulation addresses an academic support system for students, not health and safety issues.

4. Will the amended regulation help to ensure that all students' legal rights are respected? The amended regulation addresses an academic support system for students, not legal rights issues.

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 will not place any unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels.

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 should be no additional cost to the State and to the local school boards for compliance with this regulation.

**505 High School Graduation Requirements and Diplomas****1.0 Definitions:**

**"Career Pathway"** means ~~a planned program of at least 3 credits in sequenced or specialized courses designed to develop knowledge and skills in a particular career or academic area~~ the three (3) credits of pre planned and sequential courses required for graduation designed to develop knowledge and skills in a particular career or academic area. The Career Pathway shall be included in the Student Success Plan.

**"Credit"** means the acquisition of skills and knowledge at a satisfactory level as determined by the district and charter school boards through 135 hours (a Carnegie Unit) of actual classroom instruction or through locally approved options contained in Section 8.0.

“**Credit for Computer Literacy**” means credit granted toward graduation at any point when the student can demonstrate competency in the required skill areas either through an integrated approach, a specific course, or a demonstration of accumulated knowledge over the student's educational career.

“**Department**” means the Delaware Department of Education.

“**English Language Arts**” means those components of reading, writing and oral communication that are included in the State Content Standards for high school English Language Arts as required in 14 **DE Admin. Code** 501.

“**Health Education**” means those components that are included in the State Content Standards for high school health education as required in 14 **DE Admin. Code** 501.

“**High School**” means grades 9 through 12.

~~“**Individual Learning Plan (ILP)**” means a plan for a student to reach the goal of high school graduation inclusive of at least one year of post high school activity. This plan also serves as a guide for the student's choice of courses including any support services necessary for the student to graduate from high school.~~

~~“**Instructional Support Team**” means those educators, counselors and specialists or other personnel whose responsibility it is to monitor student progress in consultation with students and their parent(s), guardian(s) or Relative Caregiver and to recommend and arrange support services.~~

“**Mathematics**” means those components of number sense, algebra, geometry, statistics and probability combined with problem solving, reasoning, communicating, and making connections that are included in the State Content Standards for high school mathematics as required in 14 **DE Admin. Code** 501 either through integrated courses or in courses titles such as Algebra I, Algebra II, Geometry, Trigonometry, Pre-Calculus, Calculus, Discrete Mathematics, Statistics, and Probability.

“**Physical Education**” means those components that are included in the State Content Standards for high school physical education as required in 14 **DE Admin. Code** 501.

“**Science**” means those components of the nature of science which include inquiry, materials and their properties, energy and its effects, Earth in space, Earth's dynamic systems, life processes, diversity and continuity of living things, and ecology that are included in the State Content Standards for high school science as required in 14 **DE Admin. Code** 501 either through integrated courses or in course titles such as Earth Science, Biology ~~and~~ or Chemistry and Physics.

“**Social Studies**” means those components of civics, economics, geography, and history that are included the State Content Standards for high school social studies as required in 14 **DE Admin. Code** 501 either through integrated courses or in course titles such as United States History, World History, Geography, Economics, and Civics.

“**Student Success Plan (SSP)**” means a plan encompassing a minimum of five years including one year beyond high school developed and updated at least annually by the student, their guidance counselor, at least one other staff member and the student's parent(s) guardian(s) or relative caregiver. The student's plan includes courses needed in preparation for immediate entry into the work force or opportunities in post secondary education. The plan also includes the support services necessary for the student to graduate from high school. An additional year of high school may be an option for inclusion in the Student Success Plan.

“**Support Services**” means those academic interventions such as tutoring; extra time before school, in school, or after school; summer school, a fifth year of high school or any other strategy to provide student academic assistance.

“**World Languages**” RESERVED

## 2.0 Current Graduation Requirements

2.1 A public school student shall be granted a State of Delaware Diploma when such student has successfully completed a minimum of twenty two credits in order to graduate including: 4 credits in English Language Arts, 3 credits in mathematics, 3 credits in science, 3 credits in social studies, 1 credit in physical education, 1/2 credit in health, 1 credit in computer literacy, 3 credits in a Career Pathway, and 3 1/2 credits in elective courses.

## 3.0 Graduation Requirements Beginning with the Class of 2011 (Freshman Class of 2007-2008)

3.1 Beginning with the graduating class of 2011, a public school student shall be granted a State of Delaware Diploma when such student has successfully completed a minimum of twenty two (22) credits in order to graduate including: four (4) credits in English Language Arts, four (4) credits in Mathematics; three (3) credits in

Science, three (3) credits in Social Studies, one (1) credit in physical education, one half (1/2) credit in health education, three (3) credits in a Career Pathway, and three and one half (3 ½) credits in elective courses.

3.1.1 Students shall complete mathematics course work that includes no less than the equivalent of the traditional requirements of Geometry, Algebra I and Algebra II courses.

3.1.2 Scientific investigations related to the State Science Standards shall be included in all three science course requirements.

3.1.3 During the senior year students shall maintain a credit load each semester that earns them at least a majority of credits that could be taken that semester including one (1) of the four credits required in Mathematics.

3.1.3.1 Senior year credits shall include regular high school course offerings, the options available in 8.0 or a combination of both.

3.1.3.1.1 Options for the senior year in 3.1.3.1 that the districts and charter schools provide shall be submitted to the Department with a copy to the office of the State Board of Education for review.

#### **4.0 ~~Monitoring Student Progress~~**

~~4.1 Beginning with the 2007-2008 school year each district or charter school board, as applicable, shall require each middle school to develop an Individual Learning Plan (ILP) for all eighth grade students. ILPs shall be developed by the guidance counselor, the student, the student's parent(s), guardian(s) or Relative Caregiver, and at least one core content teacher. For the 2007-2008 school year only each district or charter school board, as applicable, shall also require each high school to develop an Individual Learning Plan (ILP) for all ninth grade students.~~

~~4.2 Beginning with the 2007-2008 school year each high school shall establish Instructional Support Teams to monitor student progress in consultation with students and their parent(s), guardian(s) or Relative Caregiver to recommend and arrange support services.~~

~~4.2.1 Each marking period student progress on the ILP shall be monitored by Instructional Support Teams. Students not making satisfactory progress in the courses required for graduation in English Language Arts, Mathematics, Science or Social Studies shall receive support services.~~

~~4.2.2 Students who have failed courses required for graduation in English Language Arts, Mathematics, Science or Social Studies at the end of any high school year may have their ILP revised to include appropriate support services. A fifth year of high school may be an option for inclusion in the student's ILP. Changes in a student's ILP shall require consultation with the student and with the student's parent(s), guardian(s) or Relative Caregiver, if appropriate.~~

#### **4.0 Student Success Plan (Personalizing the High School Experience)**

4.1 Beginning with the 2007-2008 school year, every eighth and ninth grade student shall have a Student Success Plan (SSP) developed by the student, their guidance counselor, at least one other school staff member and the student's parent(s), guardian(s) or relative caregiver.

4.2 Each local school district and charter school shall establish a process for developing Student Success Plans that includes:

4.2.1 Monitoring student progress, at a minimum, by the end of each marking period in those courses required for graduation.

4.2.2 Providing support services if a student is failing or in danger of failing courses required for graduation, and

4.2.3 Annual updating of the Student Success plans by the student, their advisor and others as appropriate.

4.2.4 Following the guidelines for Career and Technical Education (CTE) programs of study outlined in the CTE State Plan.

#### **5.0 Credit Requirements Beginning with the Graduation Class of 2013 (Freshman Class of 2009-2010)**

5.1 Beginning with the graduating class of 2013, a public school student shall be granted a State of Delaware Diploma when such student has successfully completed a minimum of twenty four (24) credits in order to graduate including: four (4) credits in English Language Arts, four (4) credits in Mathematics, three (3) credits in Science, three (3) credits in Social Studies, two (2) credits in a World Language, one (1) credit in physical

education, one half (1/2) credit in health education, three (3) credits in a Career Pathway, and three and one half (3 ½) credits in elective courses.

5.4 5.2 World Language (RESERVED)

## 6.0 Career Pathway

~~Districts and charter school boards shall establish policies concerning the purpose and content of their Career Pathways.~~

6.1 Local school districts and charter school boards shall establish policies concerning the purpose, content, development, and approval of Career Pathways.

## 7.0 Additional Credit Requirements

7.1 District and charter school boards may establish additional credit requirements for graduation above the minimum number of credits required by the Department.

## 8.0 Options for Awarding Credit Toward High School Graduation

8.1 District and charter school boards are authorized to award credit toward high school graduation for the following activities, on the condition that the activities incorporate any applicable state content standards. Before awarding credit for any of the following activities, the districts and charter school boards shall have adopted a policy approving the activity for credit and establishing any specific conditions for the award of credit for the activity. Such policy shall be applicable to each school within the district or each charter high school.

8.1.1 Courses taken at or through an accredited community college, two or four year college.

8.1.2 Voluntary community service as defined in 14 **Del.C.** §§8901A and 8902A.

8.1.3 Supervised work experience in the school and the community which meets the educational objectives or special career interest of the individual student.

8.1.4 Independent study.

8.1.5 Correspondence Courses.

8.1.6 Distance learning courses. These courses may be delivered by the teacher to the learner in real time, online or by video.

8.1.7 High school courses taken while in the middle school in conjunction with an articulated agreement between the district middle school and the district high school(s). Such credit shall also transfer to a high school in another district or to a charter school.

8.1.8 Course credit transferred from another high school.

8.1.9 Course credit earned through summer or evening school classes, as a member of the military service or as part of the James H. Groves Adult High School.

8.1.10 Tutoring programs taught by a teacher certified in the subject being taught.

8.1.11 Course credit awarded by agencies or instrumentalities of the state other than public schools which provide educational services to students. A description of the program provided to the student, grades given, and the number of clock hours of instruction or a demonstration of competency must be provided to the school district or charter school prior to receipt of credit.

## 9.0 High School Diplomas and the Certificate of Performance

9.1 A State sanctioned diploma shall be granted to students who meet the state and local district or charter school requirements for graduation pursuant to regulation 14 **Del.C.** §152.

9.2 A State sanctioned Certificate of Performance shall be granted to students who meet the requirements of 14 **Del.C.** §152.

9.3 Diplomas from one school year shall not be issued after December 31 of the next school year.

9.4 Duplicate diplomas or certificates of performance will not be issued, but legitimate requests for validation of the diploma or the certificate of performance will be satisfied through a letter of certification. Requests for diploma information from graduates of Delaware high schools should be directed to the high school the student was attending at the time of graduation. If the school does not have the records then the student should contact the Department in Dover for a notarized letter of certification that contains the name of the applicant, the name of the school, the date of graduation, and the diploma registry number (if available).

9.5 State High School Diploma for World War II Veterans Pursuant to 14 **Del.C.** §159

9.5.1 "World War II Veteran" means any veteran who performed wartime service between December 7, 1941 and December 31, 1946. If the veteran was in the service on December 31, 1946, continuous service before July 16, 1947 is considered World War II.

9.5.2 The Department shall provide a high school diploma to any World War II veteran who:

9.5.2.1 Left a Delaware high school prior to graduation in order to serve in the armed forces of the United States.

9.5.2.2 Did not receive a high school diploma, or received a G.E.D., as a consequence of such service and,

9.5.2.3 Was discharged from the armed forces under honorable circumstances.

9.5.3 The diploma may also be awarded posthumously if the deceased veteran meets the qualifications in 9.5.2.1 through 9.5.2.3.

9.5.4 Applications for this high school diploma shall be made on forms designated by the Department and the Delaware Commission of Veterans Affairs and shall have a copy of the candidate's honorable discharge papers attached to the application.

**4 DE Reg. 995 (12/01/00)**

**5 DE Reg. 625 (09/01/01)**

**7 DE Reg. 1344 (04/01/04)**

**10 DE Reg. 547 (09/01/06)**

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## OFFICE OF THE SECRETARY

Statutory Authority: 14 Delaware Code, Section 152 (14 **Del.C.** §152)

14 **DE Admin. Code** 804, 811, 815 and 817

## PUBLIC NOTICE

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

#### **804 Immunizations; 811 School Health Record Keeping Requirements; 815 Physical Examinations and Screening; 817 Administration of Medications and Treatments**

#### **A. Type of Regulatory Action Required**

Amendment to Existing Regulations

#### **B. Synopsis of Subject Matter of the Regulation**

The Secretary of Education intends to amend the following: 14 **DE Admin. Code** 804 Immunizations, 14 **DE Admin. Code** 811 School Health Record Keeping Requirements, 14 **DE Admin. Code** 815 Physical Examinations and Screening and 14 **DE Admin. Code** 817 Administration of Medications and Treatments. In addition to some formatting changes, the following comments describe the specific amendments to each of the regulations.

#### **804 Immunizations**

- 2.0, Has been reformatted.
- 2.1.1 Puts in place the new immunization nomenclature and preferred vaccines for DPT and TD
- 2.1.5 Increases the number of required dosages for Varicella vaccine from 1 to 2, but grandfathers those children who have received the 1 dose at their school entry.
- 2.1.5 States that after FY08, the schools will not accept disease history of Varicella from a parent as an exemption. The doctor will need to verify this.
- 7.0 States that school nurses must keep documentation of immunizations and report to DPH. This has been the practice and expectation, but it has never been in regulation.

**811 School Health Record Keeping Requirements**

- 1.0 Now contains definitions for the Emergency Treatment Card and the Delaware School Health Record Form
- 2.0 and 3.0 Have been reformatted.
- 3.2.1 States that electronic health records are recognized as acceptable but identifies FY08 as the last year for non-electronic formats. School all have access to eSchool or other electronic data bases and all health information must be stored electronically.
- 5.0 States that he Summary of School Health Services will be due to the Department by August 31 rather than June 30. This will allow schools to include summer school data.

**815 Physical Examinations and Screening**

- 2.2.21 Requires a follow up evaluation or referral to the student's health care provider. It has been a practice but it has never been in regulation.
- 2.3 Adds the lead screening requirements

**817 Administration of Medications and Treatments**

- 2.0 and 3.0 have been reformatted.
- 3.2 States that the medications and dosages must be FDA approved. Schools have been struggling with doctors writing large doses of antipsychotic medications for children, which are outside of the recommended doses. Also, parents bring in herbal medications. These later medications have not been tested in children, do not have directions on proper dosing, nor does one know what side effects to look for.
- 3.2.2 Recommends that an adult transport medications to the school.

Persons wishing to present their views regarding this matter may do so in writing by the close of business on or before April 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 amended regulation addresses requirements for the school nursing program not state achievement standards
2. Will the amended regulation help ensure that all students receive an equitable education? The amended regulation addresses requirements for the school nursing program not equity issues.
3. Will the amended regulation help to ensure that all students' health and safety are adequately protected? The amended regulation addresses requirements for the school nursing program that is directly related to students' health and safety.
4. Will the amended regulation help to ensure that all students' legal rights are respected? The amended regulation addresses requirements for the school nursing program not legal rights issues.
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 will not place any unnecessary reporting or administrative requirements or mandates upon decision makers at the local board and school levels.
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 a 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 is no additional cost to the State and to the local school boards for compliance with the regulation

## 804 Immunizations

### 4.0 ~~Definition of School Enterer~~

~~A school enterer is any child between the ages of two months and 21 years entering or being admitted to a Delaware school district for the first time, including but not limited to, foreign exchange students, immigrants, students from other states and territories and children entering from nonpublic schools.~~

### 1.0 Definition

"School Enterer" means any child between the ages of two months and 21 years entering or being admitted to a Delaware school district for the first time, including but not limited to, foreign exchange students, immigrants, students from other states and territories and children entering from nonpublic schools.

### 2.0 Minimum Immunizations Required for All School Enterers

~~Children who enter school prior to age 4 shall follow current Division of Public Health recommendations. Disease histories for measles, rubella and mumps will not be accepted unless serologically confirmed. Immunizations given up to four days prior to the minimum interval or age will be accepted.~~

~~2.1 Four or more doses of diphtheria, tetanus, pertussis (DTaP, DTP, or other approved vaccine) or diphtheria, tetanus (DT) vaccine or a combination of these vaccines with the following exceptions: (1) a child who received a fourth dose prior to the fourth birthday must have a fifth dose; (2) a child who received the first dose of Td (adult) at or after age seven may meet this requirement with only three doses of Td (adult).~~

~~2.1.1 A booster dose of Td (adult) is recommended for all students, five years after the last DTaP, DTP or DT dose was administered.~~

~~2.2 Three or more doses of inactivated polio virus (IPV), oral polio vaccine (OPV), or a combination of these vaccines with the following exception: A child who received a third dose prior to the fourth birthday must have a fourth dose.~~

~~2.3 Two doses of measles, mumps and rubella (MMR) vaccine. The first dose should be administered on or after the age of 12 months. The second dose should be administered after the fourth birthday. Individual combination vaccines of measles, mumps, rubella (MMR) can be used to meet this requirement.~~

~~2.4 Three doses of Hepatitis B vaccine beginning in the 1999-2000 school year with kindergarten and grade seven. (By adding a grade at each of the levels, by the year 2004-2005 all students will be required to have the vaccine.) Two doses of CDC approved vaccine for children ages 11 to 15 may be used.~~

~~2.5 Varicella vaccine is required beginning in the 2003-2004 school year with kindergarten and adding a grade each subsequent year. One dose is required for children through age 12. Two doses are required for children age 13 and older.~~

~~2.5.1 A written disease history, provided by the health care provider, parent, legal guardian, Relative Caregiver or school enterer who has reached the statutory age of majority (18), 14 ~~Del.C.~~ §131(a)(9), will be accepted in lieu of vaccination.~~

2.1 All school enterers shall have immunizations given up to four days prior to the minimum interval or age and will include:

2.1.1 Four or more doses of diphtheria, tetanus, pertussis (DTaP, DTP, or other approved vaccine) or a combination of these vaccines with the following exceptions: a child who received a fourth dose prior to the fourth birthday shall have a fifth dose; a child who received the first dose of Td (adult) at or after age seven may meet this requirement with only three doses of Td or Tdap (adult) one booster dose of Td or Tdap (adult) is recommended by the Division of Public Health for all students at age 11 or five years after the last DTaP, DTP or DT dose was administered whichever is later.

2.1.2 Three or more doses of inactivated polio virus (IPV), oral polio vaccine (OPV), or a combination of these vaccines with the following exception: a child who received a third dose prior to the fourth birthday shall have a fourth dose.

2.1.3 Two doses of measles, mumps and rubella (MMR) vaccine. The first dose should be administered on or after the age of 12 months. The second dose should be administered after the fourth birthday. Individual combination vaccines of measles, mumps, rubella (MMR) may be used to meet this requirement.

2.1.3.1 Disease histories for measles, rubella and mumps shall not be accepted unless serologically confirmed.

2.1.4 Three doses of Hepatitis B vaccine.

2.1.4.1 For children 11 to 15 years old age, two doses of a vaccine approved by the Center for Disease Control (CDC) may be used.

2.1.4.2 Titers are not acceptable in lieu of completing the vaccine series and a disease history for Hepatitis B shall not be accepted unless serologically confirmed

2.1.5 Two doses of Varicella vaccine (beginning in the 2007-2008 school year) for new school enterers in grades K to 4. By adding a grade each year, in the year 2015-2016 all students will be required to have two doses of the vaccine.

2.1.5.1 The first dose of the Varicella vaccine should be administered on or after the age of twelve (12) months and the second at kindergarten entry.

2.1.5.2 A written disease history, provided by the health care provider, parent, legal guardian, Relative Caregiver or school enterer who has reached the statutory age of majority (18), 14 Del.C. §131(a)(9), will be accepted in lieu of the varicella vaccination.

2.1.5.2.1 Beginning in the 2008-2009 school year, a disease history for the varicella vaccination shall be verified by a health care provider to be exempted from the vaccination.

2.2 Children who enter school prior to age four (4) shall follow current Delaware Division of Public Health recommendations.

### 3.0 Certification of Immunization

3.1 The parent, legal guardian, Relative Caregiver or a school enterer who has reached the statutory age of majority (18), 14 Del.C. §131(a)(9), shall present a certificate specifying the month, day, and year that the immunizations were administered by the state a licensed health care practitioner.

3.2 According to 14 Del.C. §131, a principal or person in charge of a school shall not permit a child to enter into school without acceptable evidence of immunization. The parent, legal guardian, Relative Caregiver or a school enterer who has reached the statutory age of majority (18), 14 Del.C. §131(a)(9), shall be notified of this requirement in writing. Within 14 calendar days after notification, evidence must be presented to the school that the basic series of immunizations has been initiated or has been completed.

3.3 A school enterer may be conditionally admitted to a Delaware school district by presenting a statement from a state licensed health care practitioner who specifies that the school enterer has received at least:

3.3.1 ~~Has received at least e~~One dose of DTaP, or DTP, or DT<sub>i</sub> and

3.3.2 ~~Has received at least e~~One dose of IPV or OPV<sub>i</sub> and

3.3.3 ~~Has received at least e~~One dose of measles, mumps and rubella (MMR) vaccine; and

3.3.4 ~~Has received the~~ The first dose of the Hepatitis B series as per 2.4; and

3.3.5 ~~Has received at least e~~One dose of Varicella vaccine as per 2.5.

3.4 ~~Regulation 14 DE Admin. Code~~ 901 Education of Homeless Children and Youth 6.0 states that "School districts shall ensure that policies concerning immunization, guardianship and birth certificates do not create barriers to the school enrollment of homeless children and youth". To that end, school districts shall as in ~~6-4~~ 14 DE Admin. Code "assist homeless children and youth in meeting the immunization requirements".

3.5 If the school enterer fails to complete the series of required immunizations the parent, legal guardian, Relative Caregiver or a school enterer who has reached the statutory age of majority (18), 14 Del.C. §131(a)(9), will shall be notified that the child school enterer will be excluded according to 14 Del.C. §131.

### 4.0 Lost or Destroyed Immunization Record

When an immunization record has been lost or destroyed by the medical provider who administered the vaccine, the parent, legal guardian, Relative Caregiver or a school enterer who has reached the statutory age of majority (18), 14 Del.C. §131(a)(9), shall sign a written statement to this effect and must obtain at least one dose of

~~DTaP, DTP or DT, one dose of IPV or OPV, one dose of Hepatitis B (as per 2.4) immunization against measles, mumps and rubella and one dose of varicella (as per 2.5) each of the immunizations as identified in 3.3. Evidence that the vaccines were administered shall be presented to the superintendent or designated person his or her designee. An exemption to this requirement would be a statement from a state licensed health care practitioner demonstrating serological evidence of immunity to measles, mumps or rubella.~~

## **5.0 Exemption from Immunization**

5.1 Exemption from this requirement may be granted in accordance with 14 **Del.C.** §131 that permits approved medical and notarized religious exemptions.

5.2 Alternative dosages or immunization schedules may be accepted with the written approval of the Delaware Division of Public Health.

## **6.0 Verification of School Records**

The Delaware Division of Public Health shall have the right to audit and verify school immunization records to determine compliance with the law.

## **7.0 Documentation**

7.1 School nurses shall record and maintain documentation of the student's immunization status.

7.2 The student's immunization record shall be included in the Delaware Immunization Registry.

**1 DE Reg. 1808 (5/1/98)**

**4 DE Reg. 1515 (3/1/01)**

**5 DE Reg. 2295 (6/1/02)**

## **811 School Health Record Keeping Requirements**

### **1.0 Emergency Treatment Card**

~~1.1 An Emergency Treatment Card shall be on file for each public school student. The card shall contain general emergency procedures for the care of a student when the student becomes sick or injured at school. The card shall contain the student's name, birth date, school district, school, grade, home room or teacher, home address, home telephone and the name, place of employment and work telephone of the parent, guardian or Relative Caregiver. The card shall also contain two other names, addresses and phone numbers of individuals who can be contacted at times when the parent, guardian or Relative Caregiver can not be reached. The name and telephone number of the family physician and family dentist, any medical conditions or allergies the student has and the student's medical insurance shall be on the Emergency Treatment Card.~~

~~1.2 The information on the Emergency Treatment Card may be shared only on a need to know basis.~~

~~1.3 The parent, guardian or Relative Caregiver or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) shall sign the card to assure they understand the purpose of the card and acknowledge the accuracy of the information.~~

### **2.0 School Health Record**

~~2.1 A School Health Record shall be prepared and updated for each public school student. This record is confidential and shall be protected so that only duly authorized persons have access to it.~~

~~2.2 When a student transfers to another school in the district or transfers to another school in or out of state, the School Health Record shall be forwarded with the student's other school records.~~

~~2.3 The School Health Record shall be maintained for the duration of the student's schooling. The school nurse shall use the Student Health History Update form to keep health records current.~~

~~2.4 The School Health Record shall remain in the general school file or nurse's file during the student's attendance in school. The school nurse shall destroy any duplicate or partial health record after entries have been transferred to the official record so that there is only one correct and up to date record.~~

~~Nonregulatory note: also see 14 **DE Admin. Code** 251 and 252 and the Delaware Public Archives Document Delaware School Districts General Records Retention Schedule.~~

~~2.5 The school nurse shall document any nursing care provided including the school name, a three point date, the person's (student, staff or visitor) first and last name, the time of arrival and departure, the~~

~~presenting complaint, the nurse's assessment intervention plan and outcome, the disposition of the situation, the parent or other contact, if appropriate, and the nurse's complete signature.~~

~~2.5.1 Accident Reporting: In addition to documenting the care given at the time of an accident, the school nurse shall also complete the Student Accident Report Form if the school nurse has referred the student for a medical evaluation regardless of whether the parent, guardian or Relative Caregiver or student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) followed through on that request or if the student missed more than one half day due to the accident.~~

### **3.0 Submission of Records**

~~The school nurse shall submit the Delaware Department of Education form, Summary of School Health Services for his or her building to the local school district or charter school designee. The district or charter school shall submit the summary of all school health services to the Department by June 30th of each school year.~~

~~7-DE-Reg-68 (7/1/03)~~

### **1.0 Definitions**

"Delaware School Health Record Form" means a form containing documentation of an student's health information, which includes but is not limited to identifying information, health history, immunizations, results of mandated testing and screenings, medical diagnoses, long term medications and referrals.

"Emergency Treatment Card" means a card containing general emergency procedures for the care of a student when the student becomes sick or injured at school. The card contains the following information: the student's name, birth date, school district, school, grade, home room or teacher, home address, home telephone, the name, place of employment and work telephone of the parent, guardian or Relative Caregiver; two other names, addresses and phone numbers of individuals who can be contacted at times when the parent, guardian or Relative Caregiver can not be reached; the name and telephone number of the family physician and family dentist; any medical conditions or allergies the student has; and the student's medical insurance.

### **2.0 Emergency Treatment Card**

2.1 An Emergency Treatment Card shall be on file for each public school student.

2.1.1 The information on the Emergency Treatment Card shall be shared only on a need to know basis.

2.1.2 The parent, guardian or Relative Caregiver or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) shall sign the Emergency Treatment Card to assure they understand the purpose of the form and acknowledge the accuracy of the information.

### **3.0 Delaware School Health Record Form**

3.1 The Delaware School Health Record Form shall be current and shall be part of the student's health record within the Cumulative Record File (14 DE Admin. Code 252) which accompanies the student when he or she moves to another school.

3.2. The Delaware School Health Record Form shall be maintained for the duration of the student's schooling and the school nurse shall use the Student Health History Update Form to keep health records current. The Delaware School Health Record Form shall remain in the nurse's file during the student's attendance in school.

3.2.1 The Delaware School Health Record Form may be maintained in hard copy or within an electronic documentation program and transferred electronically. Beginning with the 2008-2009 school year, all Delaware School Health Records Forms shall be in an electronic format.

Non regulatory note: also see 14 DE Admin. Code 251 and 252 and the Delaware Public Archives Document Delaware School Districts General Records Retention Schedule.

### **4.0 Other Required Documentation**

4.1 The school nurse shall document any nursing care provided including the school name, a three point date, the person's (student, staff or visitor) first and last name, the time of arrival and departure, the presenting complaint, the nurse's assessment intervention and the outcome, the disposition of the situation, the parent or other contact, if appropriate, and the nurse's complete signature or initials.

4.1.1 The school nurse shall document the care given at the time of a school based accident by

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completing the Student Accident Report Form if the student missed more than one half day because of the accident or if the school nurse has referred the student for a medical evaluation regardless of whether the parent, guardian or Relative Caregiver or student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) followed through on that request.

## **5.0 Submission of Records**

5.1 All local school districts and charter schools shall submit the Summary of School Health Services Form, to the Delaware Department of Education by August 31st of each year.-The form shall include all of the school health services provided in all schools during the fiscal year including summer programs.

## **815 Physical Examinations and Screening**

### **1.0 Physical Examinations**

1.1 All public school students shall have a physical examination that has been administered by a licensed medical physician, nurse practitioner or physician's assistant. The physical examination shall have been done within the two years prior to entry into school. Within fourteen calendar days after notification of the requirement for a physical examination, new enterers shall have received a physical examination or shall have a documented appointment with a licensed health care provider for a physical examination.

1.1.1 The requirement for the physical examination may be waived for students whose parent, guardian or Relative Caregiver, or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) presents a written declaration acknowledged before a notary public, that because of individual religious beliefs, they reject the concept of physical examinations.

1.1.2 The school nurse shall record all findings on the ~~School Health Record~~ Delaware School Health Record Form (see 14 DE Admin. Code 811) and maintain the original copy in the child's medical file.

### **2.0 Screening**

#### **2.1 Vision and Hearing Screening**

2.1.1 ~~Beginning with the school year 2004-2005, each~~ Each public school student in kindergarten and in grades 2, 4, 7 and grades 9 or 10 shall receive a vision and a hearing screening by January 15th of each school year.

2.1.1.1 In addition to the screening requirements in 2.1.1, screening shall also be provided to new enterers, students referred by a teacher or an administrator, and students considered for special education.

2.1.1.1.1 Driver education students shall have a vision screening within a year prior to their in car driving hours.

2.1.2 The school nurse shall record the results on the Delaware School Health Record Form and shall notify the parent, guardian or Relative Caregiver or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) if the student has a suspected problem.

#### **2.2 Postural and Gait Screening**

2.2.1 Each public school student in grades 5 through 9 shall receive a postural and gait screening by December 15th.

2.2.2 The school nurse shall record the findings on the ~~school health record~~ Delaware School Health Record Form (see 14 DE Admin. Code 811) and shall notify the parents, guardian or Relative Caregiver, or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) if a suspected deviation has been detected.

2.2.2.1 If a suspected deviation is detected, the school nurse shall refer the student for further evaluation through an on site follow up evaluation or a referral to the student's health care provider.

#### **2.3 Lead Screening**

2.3.1 The Childhood Lead Poison Prevention Act, 16 Del.C. Ch.26, requires all health care providers to order lead screening for children at or around the age of 12 months of age.

2.3.1.1 Child care facilities, public and private nursery schools, preschools and kindergartens shall require documentation of lead screening at the time of registration. Children shall be excluded from school after 60 days from the date of enrollment if the documentation of lead screening is not provided.

2.3.2 The school nurse shall document the lead screening on the Delaware School Health Record Form (see 14 DE Admin. Code 811).

7 DE Reg. 68 (7/1/03)

## 817 Administration of Medications and Treatments

### 1.0 Administration of Medications and Treatment

1.1 Medications, in their original container, and treatments may be administered to a public school student by the school nurse when a written request to administer the medication or treatment is on file from the parent, guardian or Relative Caregiver or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a). The school nurse shall check the student health records and history for contra indications and all allergies, especially to the medications, and shall provide immediate medical attention if an allergic reaction is observed or make a referral if symptoms or conditions persist. The school nurse shall also document the student's name, the name of medication and treatment administered, the date and time it was administered and the dosage if medication was administered.

### 2.0 Licensed Health Care Provider

~~Any prescribed medication or treatment administered to a student, in addition to the requirements in 1.0, shall be prescribed by a licensed health care provider. Prescription medication shall be properly labeled with the student's name; the licensed health care provider's name; the name of the medication; the dosage; how and when it is to be administered; the name and phone number of the pharmacy and the current date of the prescription. The medication shall be in a container which meets United States Pharmacopoeia National Formulary standards.~~

~~Treatment, including, specialized health procedures, shall be signed by a licensed health care provider with directions on how and when to administer.~~

~~2.1 The prescription and the medication shall be current and long term prescriptions shall be re-authorized at least once a year.~~

~~2.2 All medications classified as controlled substances shall be counted and reconciled each month by the school nurse and kept under double lock.~~

2.1 Any prescribed medication administered to a student, in addition to the requirements in 1.0, shall be prescribed by a licensed health care provider. Treatment, including specialized health procedures, shall be signed by a licensed health care provider with directions relative to administration or supervision.

### 3.0 Prescription Medications

3.1 Prescription medication shall be properly labeled with the student's name; the licensed health care provider's name; the name of the medication; the dosage; how and when it is to be administered; the name and phone number of the pharmacy and the current date of the prescription. The medication shall be in a container which meets United States Pharmacopoeia National Formulary standards.

3.2 Medications and dosages administered by the school nurse shall be approved by the Federal Drug Administration (FDA) and comply with FDA recommendations.

3.2.1 The prescription and the medication shall be current and long term prescriptions shall be re authorized at least once a year.

3.2.2 All medications classified as controlled substances shall be counted and reconciled each month by the school nurse and kept under double lock. Such medications should be transported to and from school by an adult.

### ~~3~~ 4.0 Non Prescription Medications

4.1 Non prescription medications may be given by the school nurse after the nurse assesses the complaint and the symptoms to determine if other interventions can be used before medication is administered and if all requirements in 1.0 have been met.

### 4 5.0 IEP Team

5.1 For a student who requires significant medical or nursing interventions, the Individual Education Program (IEP) team shall include the school nurse.

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## § 6.0 Assistance With Medications on Field Trips

### § 6.1 Definitions

"**Assist a Student with Medication**" means assisting a student in the self administration of a medication, provided that the medication is in a properly labeled container as hereinafter provided. Assistance may include holding the medication container for the student, assisting with the opening of the container, and assisting the student in self administering the medication. Lay assistants shall not assist with injections. The one exception is with emergency medications where standard emergency procedures prevail in lifesaving circumstances.

"**Field Trip**" means any off campus, school sponsored activity.

"**Medication**" means a drug taken orally, by inhalation, or applied topically, and which is either prescribed for a student by a physician or is an over the counter drug which a parent, guardian or Relative Caregiver has authorized a student to use.

"**Paraeducator**" mean teaching assistants or aides.

§ 6.2 Teachers, administrators and paraeducator employed by a student's local school district are authorized to assist a student with medication on a field trip subject to the following provisions:

§ 6.2.1 Assistance with medication shall not be provided without the prior written request or consent of a parent, guardian or Relative Caregiver (or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a). Said written request or consent shall contain clear instructions including: the student's name; the name of the medication; the dose; the time of administration; and the method of administration. At least one copy of said written request or consent shall be in the possession of the person assisting a student with medication on a field trip.

§ 6.2.2 The prescribed medication, in addition to the requirements in 1.0, shall be prescribed by a licensed health care provider. The medication shall be properly labeled with the student's name; the licensed health care provider's name; the name of the medication; the dosage; how and when it is to be administered; the name and phone number of the pharmacy and the current date of the prescription. The medication shall be in a container which meets United States Pharmacopoeia National Formulary standards.

§ 6.2.3 A registered nurse employed by the school district in which the student is enrolled shall determine which teachers, administrators and paraeducators are qualified to safely assist a student with medication. In order to be qualified, each such person shall complete a Board of Nursing approved training course developed by the Delaware Department of Education, pursuant to 24 **Del.C.** §1921. Said nurse shall complete instructor training as designated by the Department of Education and shall submit a list of successful staff participants to the Department of Education. No person shall assist a student with medication without written acknowledgment that he/she has completed the course and that he/she understands the same, and will abide by the safe practices and procedures set forth therein.

§ 6.2.4 Each school district shall maintain a record of all students receiving assistance with medication pursuant to this regulation. Said record shall contain the student's name, the name of the medication, the dose, the time of administration, the method of administration, and the name of the person assisting.

§ 6.2.5 Except for a school nurse, no employee of a school district shall be compelled to assist a student with medication. Nothing contained herein shall be interpreted to otherwise relieve a school district of its obligation to staff schools with certified school nurses.

Nonregulatory note: 14 **DE Admin. Code** 612, *Possession, Use and Distribution of Drugs and Alcohol* addresses student self administration of a prescribed asthmatic quick relief inhaler and student self administration of prescribed autoinjectable epinephrine.

**7 DE Reg. 68 (7/1/03)**

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# PROPOSED REGULATIONS

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## DEPARTMENT OF HEALTH AND SOCIAL SERVICES DIVISION OF Social Services

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

### PUBLIC NOTICE

#### Child Care Subsidy Program 11006.6 Complaints

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 Social Services is proposing to amend child care subsidy program policies in the Division of Social Services Manual (DSSM).

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, Program and Development Unit, Division of Social Services, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to (302) 255-4425 (new fax number) by April 30, 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

#### Statutory Authority

- The Child Care and Development Block Grant (part of Categories 31 and 41) as amended by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996; and,
- Title XX of the Social Security Act.

#### Summary of Proposed Change

DSSM 11006.6, *Complaints* is revised to clarify the complaint process for the child care program. This revision also adds the requirement to send a copy of the complaint to the Child Care Monitor.

#### DSS PROPOSED REGULATION #07-14 REVISIONS:

#### 11006.6 Complaints

##### Client Complaints

~~Clients are informed as to how they~~ may make a complaint when they believe a facility is not meeting the licensing regulations or the provisions of the DSS contract. When a client makes a complaint to a Case Manager, the Case Manager will complete a Client Provider Complaint Information Form (Form 633), and forward it Forward the complaint to the Office of Child Care Licensing ~~or with a copy to the Child Care Monitor for action.~~ Licensing will send results of the investigation to the Child Care Administrator.

##### Provider Complaints

~~Providers may make complaints regarding clients should be forwarded to the Food Stamp Employment & Training Case Manager. The complaint should be~~ in writing. ~~Provider complaints regarding the system must conform to the Miscellaneous Conditions section of the Day Care Contract.~~

Send provider complaints regarding DSS provider contracts or payments process to the Child Care Administrator.

## DEPARTMENT OF INSURANCE

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

18 **DE Admin. Code** 1301

### PUBLIC NOTICE

#### 1301 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](http://www.delawareinsurance.gov) and clicking on the link for "Proposed Regulations."

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., Wednesday, May 2, 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](mailto:michael.rich@state.de.us).

#### ~~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 provided. 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 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~~

# PROPOSED REGULATIONS

~~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 \_\_\_\_\_

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) \_\_\_\_\_

# PROPOSED REGULATIONS

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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 \_\_\_\_\_

Claim Number Assigned By Respondent \_\_\_\_\_

Date Of Determination Of Independent Review Process \_\_\_\_\_

Amount Of Claim Admitted By Respondent \_\_\_\_\_

Dates Of Service \_\_\_\_\_

# PROPOSED REGULATIONS

(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.

# PROPOSED REGULATIONS

**"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

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# PROPOSED REGULATIONS

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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 services to a non-network emergency care provider who was a network emergency care provider at any time prior to the date the provider delivered the emergency care services which are the subject of the arbitration.* A carrier shall pay such non-network emergency care provider the higher of either (1) the highest contract rate for the services provided during the term of the provider's contract with the insurer, subject to such rate adjustments as may be published in bulletins by the Commissioner from time to time, 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.

7.3.2 Other payments for emergency care services with CPT codes. A carrier shall pay non-network emergency care providers who were never network providers with the carrier 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.

7.3.3 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.

7.3.4 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.

7.4 Duty to Arbitrate. Every carrier and provider shall submit to arbitration pursuant to this Section 7.0 all fee disputes arising from the provision of emergency care services under 18 Del.C. §3349 and 3565, except as provided in Section 5.4.

## **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 AURA'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 AURA'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:

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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 June 11, 2007. Pursuant to the orders of the Commissioner dated January 8, 2007 and March 15, 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.

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## **DEPARTMENT OF INSURANCE**

Statutory Authority: 18 Delaware Code, Section 311 (18 Del.C. §311)  
18 DE Admin. Code 1307

### **Public Notice of Proposed Changes to the Department of Insurance's Regulation Relating to Group Coordination Benefits**

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of a proposed change to **Regulation 1307** relating to **Group Coordination Benefits**. The docket number for this proposed amendment is 383.

The proposed change to the regulation provides that, upon the request of either parent of a dependent child, a carrier shall provide an insurance card to the requesting parent and that if the benefits are not assigned and would be paid to an individual other than the provider, the carrier shall issue the benefits to the parent who sought the treatment for the dependent child. The regulation will also contain non-substantive changes to the numbering of the sections and non-substantive wording changes for better clarity. 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., Wednesday May 2, 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 E-mail to [michael.rich@state.de.us](mailto:michael.rich@state.de.us).

### **1307 Group Coordination Benefits [Formerly Regulation 61]**

#### **1.0 Authority**

1.1 This regulation is adopted and promulgated by the Insurance Commissioner pursuant to 18 Del.C. §311 and promulgated under 29 Del.C. Ch. 101.

1.2 The purpose of the regulation is to:

- 1.2.1 permit, but not require, plans to include a coordination of benefits ("COB") provision;
- 1.2.2 establish an order in which plans pay their claims;
- 1.2.3 provide the authority for the orderly transfer of information needed to pay claims promptly;

~~1.2.4 reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan, pursuant to rules established by this regulation, does not have to pay its benefits first;~~

~~1.2.5 reduce claims payment delays; and~~

~~1.2.6 make all contracts that contain a COB provision consistent with this regulation.~~

~~1.3 The purpose of this Regulation is to encourage coordination of benefits, and is not intended to limit in any way the right to coordinate benefits which provide health coverage.~~

## **2.0 Purpose and Applicability**

2.1 The purposes of this regulation is are to:

2.1.1 permit, but not require, plans to include a coordination of benefits ("COB") provision;

2.1.2 establish an order in which plans pay their claims;

2.1.3 provide the authority for the orderly transfer of information needed to pay claims promptly;

~~2.1.4 reduce duplication of benefits by permitting a reduction of the benefits paid by a plan when the plan, pursuant to rules established by this regulation, does not have to pay its benefits first;~~

2.1.5 reduce claims payment delays; and

2.1.6 make all contracts that contain a COB provision consistent with this regulation.

2.2 The purpose of this Regulation is to encourage coordination of benefits, and is not intended to limit in any way the right to coordinate benefits which provide health coverage.

## **3.0 Definitions**

3.1 The following words and terms, when used in this regulation, shall have the following meanings unless the context clearly indicates otherwise.

3.2 "Allowable Expense(s)" means the necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

3.2.1 Notwithstanding the above definition, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of Allowable Expense. A plan which provides benefits only for any such items of expense may limit its definition of Allowable Expenses to like items of expense.

3.2.2 When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

3.2.3 The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

3.2.4 When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of "Allowable Expense" must include the corresponding expenses or services to which COB applies.

3.3 "Claim" means a request that benefits of a plan be provided or paid is a claim. The benefits claimed may be in the form of:

3.3.1 services (including supplies);

3.3.2 payment for all or a portion of the expenses incurred;

3.3.3 a combination of sections 3.3.1 and 3.3.2 above; or

3.3.4 an indemnification.

3.4 "Claim Determination Period" is the period of time, which must not be less than twelve consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine whether overinsurance exists and how much each plan will pay or provide.

3.4.1 The Claim Determination Period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period.

3.4.2 As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. But that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

3.5 "Coordination of Benefits" is a provision establishing an order in which plans pay their claims.

3.6 "Hospital Indemnity Benefits" are benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

3.7 "Plan" means a form of coverage with which coordination is allowed. The definition of Plan in the group contract must state the types of coverage which will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition.

3.7.1 The definition shown in the Model COB Provision, attached to this rule as Appendix A, is an example of what may be used. Any definition that satisfies this subsection may be used.

3.7.2 ~~This subsection uses the term "plan." However, a group contract may, instead, use "program" or some other term.~~ When describing a plan, an insurer may use the term "program" or other similar term to describe the coverage under a plan.

3.7.3 Plan may include:

3.7.3.1 Group insurance and group subscriber contracts;

3.7.3.2 Uninsured arrangements of group or group-type coverage;

3.7.3.3 Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;

3.7.3.4 Group-type contracts. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of plan, at the option of the insurer or the service provider and the contract client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket"). Individually underwritten and issued guaranteed renewable policies would not be considered "group-type" even savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

3.7.3.5 The amount by which group or group-type hospital indemnity benefits exceed \$100 per day;

3.7.3.6 The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and

3.7.3.7 Medicare or other governmental benefits, except as provided in section 3.7.3.8.7 below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

3.7.3.8 Plan shall not include:

3.7.3.8.1 Individual or family insurance contracts;

3.7.3.8.2 Individual or family subscriber contracts;

3.7.3.8.3 Individual or family coverage through Health Maintenance Organizations (HMOs);

3.7.3.8.4 Individual or family coverage under other prepayment, group practice and individual practice plans;

3.7.3.8.5 Group or group-type hospital indemnity benefits of \$100.00 per day or less;

3.7.3.8.6 School accident-type coverages. These contracts cover grammar, high school and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis; and

3.7.3.8.7 A State plan under Medicaid, and shall not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

3.8 "Primary Plan" is a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a Primary Plan if either of the following conditions is true:

3.8.1 The plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this subchapter. There may be more than one Primary Plan; or

3.8.2 All plans which cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

3.9 "Secondary Plan" is a plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this regulation decide the order in which their benefits

are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that Secondary Plan.

3.10 "This Plan" in a COB provision, refers to the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from This Plan. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

#### **4.0 Model Cob Contract Provision**

4.1 Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of sections 4.2, and 4.3 and ~~to the provisions of section 5.0.~~

4.2 A group contract's COB provision does not have to use the words and format shown at Appendix A. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No other substantive changes are allowed.

4.3 A group contract may not reduce benefits on the basis that:

- 4.3.1 another plan exists;
- 4.3.2 a person is or could have been covered under another plan, except with respect to Part B of Medicare; or
- 4.3.3 a person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

4.4 No contract may contain a provision that its benefits are "excess" or "always secondary" to any plan as defined in this regulation, except in accord with the rules permitted by this regulation.

#### **5.0 Rules for Coordination of Benefits**

5.1 The general order of benefits is as follows:

5.1.1 The Primary Plan must pay or provide its benefits as if the Secondary Plan or Plans did not exist. A Plan that does not include a coordination of benefits provision may not take the benefits of another Plan as defined in section 3.0, ~~definitions~~ into account when it determines its benefits. There is one exception: a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.

5.1.2 A Secondary Plan may take the benefits of another plan into account only when, under these rules, it is Secondary to that other plan.

5.1.3 The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than a dependent) are determined before those of the plan which covers the person as a dependent.

5.2 The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:

5.2.1 The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;

5.2.2 If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;

5.2.3 The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;

5.2.4 A group contract which includes COB and which is issued or renewed, or which has an anniversary date on or after sixty days after the effective date of this subchapter shall include the substance of the provision in sections 5.2.1, 5.2.2, and 5.2.3 above. Until that provision becomes effective, the group contract may instead contain wording such as: "Except as stated in section 5.1.3, the benefits of a plan which covers the person as a dependent of a female."

5.2.5 If the other plan does not have the rule described in sections 5.2.1, 5.2.2, and 5.2.3 above but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

5.3 If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- 5.3.1 First, the plan of the parent with custody of the child;
- 5.3.2 Then, the plan of the spouse of the parent with the custody of the child; and
- 5.3.3 Finally, the plan of the parent not having custody of the child.
- 5.3.4 If the specific terms of a court decree state that one of the parents is responsible for the

health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

5.3.5 Upon request by either parent of a dependent child, a carrier subject to this Section 5.3 shall immediately issue an insurance card showing proof of applicable insurance for the dependent child to the parent making such request.

5.3.6 If benefits are not assigned and would be paid to an individual other than the provider, the carrier shall issue the benefits to the parent who sought the treatment for the dependent child.

5.4 The benefits of a plan which ~~that~~ covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5.5 If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter term.

5.5.1 To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within twenty-four hours after the first ended.

5.5.2 The start of a new plan does not include:

5.5.2.1 a change in the amount of scope of a plan's benefits;

5.5.2.2 a change in the entity which pays, provides or administers the plan's benefits; or

5.5.2.3 a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

5.5.3 The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

## **6.0 Procedure to be Followed by Secondary Plan**

### **6.1 Total Allowable Expenses**

6.1.1 When it is determined, pursuant to section 5.0, that this Plan is a Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than total Allowable Expenses. The amount by which the Secondary Plan's benefits have been reduced shall be used by the Secondary Plan to pay Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

6.1.2 The benefits of the Secondary Plan will be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Secondary Plan in the absence of the COB provision and the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of the Secondary Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

6.1.2.1 When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

6.1.2.2 Section 6.1.2.1 above may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

## **7.0 Miscellaneous Provisions**

### **7.1 Reasonable Cash Values of Services**

7.1.1 A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan which provides benefits in the form of services.

## 7.2 Excess and Other Nonconforming Provisions

7.2.1 Some plans have order of benefit determination rules not consistent with this regulation which declare that the plan's coverage is "excess" to all others, or "always secondary." This occurs because certain plans may not be subject to insurance regulation, or because some group contracts have not yet been conformed with to this regulation pursuant to section 2.0.

7.2.2 A plan with order of benefit determination rules which comply with this regulation (Complying Plan) may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this regulation (Noncomplying Plan) on the following basis:

7.2.2.1 If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis;

7.2.2.2 If the Complying Plan is the Secondary Plan, it shall, never the less, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, such payment shall be the limit of the Complying Plan's liability; and

7.2.2.3 If the Noncomplying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Noncomplying Plan are identical to its own, and shall pay its benefits accordingly. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

7.2.3 If the Noncomplying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Noncomplying Plan paid or provided its benefits as the Primary Plan, and governing State law allows the right of subrogation set forth below, then the Complying Plan shall advance to or on behalf of the employee, subscriber or member an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all rights of the employee, subscriber or member against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

## 7.3 Allowable Expense

7.3.1 A term such as "usual and customary," "usual and prevailing," or "reasonable and customary," may be substituted for the term "necessary, reasonable and customary." Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

## 7.4 Subrogation

7.4.1 The COB concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion of the other.

## 8.0 Effective Date; Compliance Dates of Existing Contracts

8.1 ~~This subchapter is applicable to every group contract which provides health care benefits and which is issued on or after the effective date of this regulation, which is 30 days after signature of the Commissioner. This regulation first became effective on October 6, 1988. The amendments hereto shall become effective on June 11, 2007.~~

8.2 A group contract which provides health care benefits and was issued before the effective date of this regulation shall be brought into compliance with this regulation by the later of:

8.2.1 the next anniversary date or renewal date of the group contract; or

8.2.2 the expiration of any applicable collectively bargained contract pursuant to which it was written.

### Appendix A. Model Cob Provisions Coordination Of The Group Contracts Benefits With Other Benefits

**I. Applicability**

A. This Coordination of Benefits "COB" provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

(1) Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

(2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section IV "Effect on the Benefits of This Plan."

**II. Definitions**

A. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under (1) or (2) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of the group contract that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

D. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

**III. Order Of Benefit Determination Rules**

A. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(1) The other plan has rules coordinating its benefits with those of This Plan; and

(2) Both those rules and This Plan's rules, in Subsection B below, require that This Plan's benefits be determined before those of the other plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(1) Non-Dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(2) Dependent Child/Parents not Separated or Divorced. Except as stated in Paragraph (B)(3)

below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents":

(a) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time. However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(3) **Dependent Child/Separated or Divorced.** If two or more plans cover a person as a dependent child of divorces or separated parents, benefits for the child are determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has the actual knowledge.

(d) Upon request by either parent of a dependent child, a carrier subject to this Section 5.3 shall immediately issue an insurance card showing proof of applicable insurance for the dependent child to the parent making such request.

(e) If benefits are not assigned and would be paid to an individual other than the provider, the carrier shall issue the benefits to the parent who sought the treatment for the dependent child.

(4) **Active/Inactive Employee.** The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule (4) is ignored.

(5) **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

#### **IV. Effect On The Benefits Of This Plan**

A. When This Section Applies. This Section IV applies when, in accordance with Section III "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expense under This Plan in the absence of the COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

#### **V. Right To Receive And Release Needed Information**

Certain facts are needed to apply these COB rules. [Insurer] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. [Insurer] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give [insurer] any facts it needs to pay the claim.

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## 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

SAN # 2005-10

**1. Title of the Regulations:**

Regulation No. 1148, "Control Of Stationary Combustion Turbine Electric Generating Unit Emissions"

**2. Brief Synopsis of the Subject, Substance and Issues:**

DNREC is proposing to develop a new regulation to reduce emissions of nitrogen oxides (NO<sub>x</sub>) from combustion turbine electric generating units, typically known as peaking units.

Delaware's emission inventory data demonstrates that combustion turbines in Delaware are significant NO<sub>x</sub> emitting sources. While some combustion turbines in Delaware generate electricity to meet base-load demands, other combustion turbines generate electricity to meet peak demands. Those periods of peak demand frequently correspond with summer ozone action days. This means that emissions from these units are frequently at their highest when the health threat from ozone is at its worst. Many of Delaware's peaking units have high emission rates of nitrogen oxides and, therefore, should be evaluated for additional NO<sub>x</sub> emission controls.

The proposed regulation will also reduce NO<sub>x</sub> emissions in the State of Delaware from the subject units during high electric demand days (HEDD). This will meet Delaware's obligation to support the regional HEDD NO<sub>x</sub> reduction initiative for the units subject to this regulation.

**3. Possible Terms of the Agency Action:**

None

**4. Statutory Basis or Legal Authority to Act:**

7 Delaware Code, Chapter 60

**5. Other Regulations That May Be Affected by the Proposal:**

Regulation No. 12, "Control of Nitrogen Oxides Emissions" may be amended in a subsequent effort to clarify Reasonably Available Control Technology (RACT) requirements as those requirements relate to the units subject to the proposed regulation.

**6. Notice of Public Comment:**

The public comment period for this proposed regulation will extend through at least May 1, 2007. Interested parties may submit comments in writing during this time frame to: Mark A. Prettyman, Air Quality Management Section, 156 S. State St., Dover, DE 19901, and/or statements and testimony may be presented either orally or in writing at the public hearing to be held on Thursday, April 26, 2007, beginning at 6:00 PM in the DNREC auditorium at the Richardson and Robbins Building, 89 Kings Highway, Dover, DE 19901.

**7. Prepared By:**

Mark A. Prettyman 302-739-9402      3/15/2007

Name/Phone #                                      Date

Email address:              mark.prettyman@state.de.us

**1148 Control of Stationary Combustion Turbine Electric Generating Unit Emissions**

**xx/xx/2007**

**1.0 Purpose.**

The purpose of this regulation is to control the emissions of nitrogen oxides (NOx) from stationary combustion turbine electric generating units in the State of Delaware to reduce the impact on public health, safety, and welfare. This regulation will also reduce NOx emissions in the State of Delaware from the subject units during high electric demand days (HEDD). This will meet Delaware's obligation to support the regional HEDD NOx reduction initiative for the units subject to this regulation.

xx/xx/2007

**2.0 Applicability.**

2.1 This regulation applies to existing, stationary combustion turbine electric generating units located in Delaware with a base-load nameplate capacity of 1 MW or greater.

2.2 This regulation is not applicable to existing stationary combustion turbine electric generating units that are subject to Regulation No. 12, "Control of Nitrogen Oxides Emissions," and meet the NOx emissions limitations identified in Table II of Regulation No. 12, and are not otherwise exempt from the NOx emissions limitations of Table II of Regulation No. 12.

xx/xx/2007

**3.0 Definitions.**

The following words and terms, when used in this regulation, shall have the following meanings:

"Annual capacity factor" means the ratio of the megawatt-hours produced in a calendar year by a stationary combustion turbine electric generating unit to the maximum possible annual electric generation determined on the base-load nameplate capacity of the stationary combustion turbine electric generating unit.

"Base-load nameplate capacity" means, starting from the initial installation of a combustion turbine electric generating unit, the maximum electrical generating output (in MWe) that the combustion turbine electric generating unit is capable of producing on a steady basis during continuous operation at rated ambient temperature and atmospheric pressure as specified by the manufacturer of the combustion turbine electric generating unit or, starting from the completion of a physical change in the combustion turbine electric generating unit resulting in an increase in the maximum electrical generating output (in MWe) that the combustion turbine electric generating unit is capable of producing on a steady state basis and during continuous operation, such increased maximum output as specified by the person conducting the physical change.

"Combustion turbine" means a combustion engine consisting of a compressor, combustor(s) and power turbine used to provide rotary motion to an output shaft. The combustion turbine may be fueled by gaseous and/or liquid fuels.

"Combustion turbine electric generating unit" means a combustion turbine used to drive an electric generator.

"Department" means the State of Delaware Department of Natural Resources and Environmental Control as defined in 29 Del.C., Chapter 80, as amended.

"Electric generator" means a device that utilizes rotary motion from an input shaft to create electrical energy.

"Existing" means the unit has been synchronized to the grid before [insert the effective date of this regulation].

"Gaseous fuel" means any non-solid or non-liquid fuel, including natural gas, digester gas, landfill gas, process gas, or any gas stored as a liquid at high pressure such as liquefied petroleum gas.

"Liquid fuel" means any non-solid or non-gaseous fuel, including kerosene, jet fuel, distillate fuel oil, bio-fuels, and methanol.

"Ozone season" means the months of April through October.

"Ozone season capacity factor" means the ratio of the megawatt-hours produced during the ozone season, as defined within this regulation, by a stationary combustion turbine electric generating unit to the maximum possible ozone season electric generation determined on the base-load nameplate capacity of the stationary combustion turbine electric generating unit.

"Peak-load nameplate capacity" means, starting from the initial installation of a combustion turbine electric generating unit, the maximum electrical generating output (in MWe) that the combustion turbine electric generating unit is capable of producing for limited durations at rated ambient temperature and atmospheric pressure as specified by the manufacturer of the combustion turbine electric generating unit or, starting from the completion of a physical change in the combustion turbine electric generating unit resulting in an increase in the

maximum electrical generating output (in MWe) that the combustion turbine electric generating unit is capable of producing for limited durations, such increased maximum output as specified by the person conducting the physical change.

“PPMV” means gaseous concentration in parts per million by volume, corrected to 15 percent O<sub>2</sub> dry basis.

“Shutdown” means the period of time between a combustion turbine generating unit being brought from an operating condition to fuel shut off. This period of time may be begun at either opening the generator breaker or disconnecting the combustion turbine from the electric generator, and is concluded when the fuel is completely shut off to the combustion turbine.

“Simple cycle” means a combustion turbine electric generating unit which does not recover heat from the combustion turbine electric generating unit exhaust gases to preheat the inlet combustion air to the combustion turbine electric generating unit, to heat water, or to generate steam.

“Start-up” means the period during which a combustion turbine generating unit is brought from a shutdown status to rated speed and generator breaker closure.

“Stationary” means a unit that is not self-propelled or intended to be propelled while performing its design function.

**xx/xx/2007**

## **4.0 NOx Emissions Limitations.**

**4.1** Beginning April 1, 2009, no existing stationary combustion turbine electric generating unit subject to this regulation shall exceed the NOx emissions limitations shown in Table I of this regulation during the ozone season, inclusive of any year:

Table I

<b>Fuel Type</b>	<b>NOx Emissions Limit (ppmv)</b>
<b>Gaseous Fuel</b>	<b>42</b>
<b>Liquid Fuel</b>	<b>88</b>

**4.2** The owner or operator of an existing stationary combustion turbine electric generating unit shall, no later than April 1, 2009, either demonstrate to the satisfaction of the Department, through source testing approved by the Department, that the existing stationary combustion turbine generating unit meets the NOx emissions limitations of Table I of this regulation or install NOx emission controls designed to meet the NOx emissions limitation of Table I of this regulation in accordance with the requirements of paragraph 4.3 of this regulation.

**4.3** The owner or operator of an existing stationary combustion turbine electric generating unit installing NOx emissions reduction controls in accordance with the requirements of paragraph 4.2 of this regulation shall install the NOx emissions reduction controls and implement operating procedures with the goal of achieving the NOx emissions limits of Table I of this regulation, and shall be designed and operated to control NOx emissions across the anticipated operating load range of the combustion turbine electric generating unit, including periods of startup, shutdown, and reduced load operation insofar as technically feasible.

**4.3.1** The owner or operator of an existing stationary combustion turbine electric generating unit installing NOx emissions reduction controls in accordance with paragraph 4.3 of this regulation, shall submit to the Department for approval an emissions control plan detailing all actions, including a schedule of increments of progress, which will be taken to comply with the requirements of paragraph 4.1 of this regulation and the emissions control limitations of Table I of this regulation. The plan shall contain, as a minimum, the following information:

**4.3.1.1** Facility and unit identification

**4.3.1.2** Combustion turbine electric generating unit manufacturer and manufacturer's model number.

**4.3.1.3** Combustion turbine electric generating unit manufacturer's base and peak (when applicable) load nameplate ratings and rating conditions (atmospheric temperature and pressure, fuel type, etc.).

**4.3.1.4** Primary and secondary (where applicable) fuel type(s) and typical fuel(s) analysis.

**4.3.1.5** Hours of operation and electrical output for the previous five years.

**4.3.1.6** Results of any previous NOx emissions testing conducted in the five calendar

years prior to [insert the effective date of this regulation].

4.3.1.7 Anticipated future operating schedule (capacity factor), annual and seasonal.

4.3.1.8 Technical description of proposed emissions control technology and equipment designed to minimize NOx emissions across the entire operating range of the existing stationary combustion turbine electric generating unit (insofar as technically feasible), predicted NOx emissions levels following controls installation, and supporting documentation. The proposed operating range of the control technology may be utilized by the Department in establishing permit limitations for startup and shutdown for the subject unit.

4.3.1.9 Compliance schedule including compliance emissions testing conducted representative of anticipated normal load range, including base load and peak load (if applicable), and anticipated monitoring plan submittal.

4.3.1.10 Any other information requested by the Department.

4.3.2 The owner or operator of an existing stationary combustion turbine electric generating unit submitting an emissions control plan in accordance with paragraph 4.3.1 of this regulation shall submit the plan to the Department for approval no later than [insert nine months from the effective date of this regulation].

4.3.3 Following completion of the approved NOx emissions control installation described in paragraphs 4.3.1 and 4.3.2 of this regulation, emissions testing approved by the Department shall be conducted to determine compliance with the NOx emissions requirements of paragraph 4.1 and the Table I of this regulation. Testing results shall be submitted to the Department no later than 60 days following the completion of the testing.

4.3.4 If actual achievable NOx emissions levels following completion of the approved emissions reduction plan are greater than those of Table I of this regulation, the owner or operator of the stationary combustion turbine electric generating unit may petition the Department for alternative NOx emissions limitations no greater than the actual achievable NOx emissions levels determined in the post-emissions control installation testing.

4.4 The NOx emissions limitations of paragraph 4.1 and Table I of this regulation, or alternate NOx emissions limitations approved by the Department in accordance with paragraph 4.3.4 of this regulation, are applicable to existing stationary combustion turbine electric generating units subject to this regulation whenever combusting fuel during the ozone season, inclusive of any year, except during periods of start-up or shutdown.

4.5 Compliance with the NOx emissions limitations of paragraph 4.1 and Table I of this regulation, or alternate NOx emissions limitations approved by the Department in accordance with paragraph 4.3.4 of this regulation, are based on one hour averaging periods.

xx/xx/2007

## **5.0 Monitoring and Reporting.**

5.1 For existing stationary combustion turbine electric generating units with an ozone season capacity factor of 10% or less for each of the five calendar years preceding [insert the effective date of this regulation], compliance emissions testing acceptable to the Department shall be conducted by the owner or operator in the calendar year before each calendar year for which the operating permit expires.

5.2 For existing combustion turbine electric generating units with an ozone season capacity factor greater than 10% for any of the five calendar years preceding [insert the effective date of this regulation], compliance emissions testing acceptable to the Department shall be conducted by the owner or operator every two years, starting in the second calendar year after [insert the effective date of this regulation].

5.3 For existing combustion turbine electric generating units in compliance with paragraph 5.1 of this regulation but which have an ozone season capacity factor of greater than 10% for any year subsequent to [insert the effective date of this regulation], compliance emissions testing acceptable to the Department shall be conducted by the owner or operator every two years, starting in the calendar year after the year that the 10% ozone season capacity factor was exceeded.

5.4 The owner or operator of an existing combustion turbine electric generating unit shall submit to the Department, for approval, a monitoring plan containing monitoring information correlating control system parameters or other operating characteristic indications with NOx emissions output.

5.4.1 The correlations may be developed using actual emissions test data and parameters and characteristics recommended by the combustion turbine electric generating unit manufacturer, emission control equipment supplier, or other operating experience. The correlations shall address the entire anticipated operating load range of the combustion turbine electric generating unit.

5.4.2 This information may be used by the Department to monitor compliance with this

regulation.

5.4.3 Representative data shall be continuously collected and recorded for any period that the combustion turbine electric generating unit combusts any fuel.

5.4.4 The approved monitoring information shall be annually submitted to the Department no later than February 1 of the year following the calendar year for which the data is collected, and shall also include detailed explanations for any periods where the monitored operating parameters were outside acceptable margins and include descriptions of corrective actions taken.

5.5 The provisions of paragraphs 5.1, 5.2, 5.3 and 5.4 of this regulation are not applicable to existing stationary combustion turbine electric generating units which are otherwise required to install, test, operate, and maintain NOx continuous emissions monitoring system in accordance with Department or EPA requirements for continuous emissions monitoring systems meeting all applicable requirements of 40 CFR Part 60 or 40 CFR Part 75 (July 1, 2006 edition).

5.6 The owner or operator of an existing stationary combustion turbine electric generating unit shall maintain an operating log that includes, on a daily basis, actual start-up and shutdown times, total hours of operation, gross electrical megawatt-hours generated, fuel consumption, type of fuel(s), identification of any periods operating outside the monitoring parameters identified in paragraph 5.4 of this regulation (where applicable), identification of any periods of non-compliance with the requirements of this regulation, cumulative-to-date hours of operation and gross electrical megawatt-hours generated, and any other information requested by the Department. This data shall be submitted annually to the Department no later than February 1 of the year following the calendar year for which the data is collected.

xx/xx/2007

**6.0 Recordkeeping.**

The owner or operator of a stationary combustion turbine electric generating unit subject to this regulation shall maintain, for a period of at least five years, copies of all measurements, tests, reports, operating logs, and other information required by this regulation. This information shall be provided to the Department upon request at any time.

xx/xx/2007

**7.0 Penalties.**

The Department may enforce all of the provisions of this regulation under 7 Del.C. Ch. 60.

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**DEPARTMENT OF STATE**

**DIVISION OF PROFESSIONAL REGULATION**

**1770 Respiratory Care Practice Advisory Council**

Statutory Authority: 24 Delaware Code, Section 1775(c) (24 Del.C. §1775(c))

**24 DE Admin. Code 1770**

**PLEASE TAKE NOTICE**, pursuant to 29 Del.C. Ch. 101 and 24 Del.C. §1775(c), the Respiratory Care Practice Advisory Council of the Delaware Board of Medical Practice proposes to revise its rules and regulations. The proposed revision adds two (2) new sections to the rules and regulations to address and regulate the administration of sedation and analgesia by respiratory care practitioners.

A public hearing will be held on the proposed rules and regulations on May 15, 2007 at 2:00 p.m., in the Second Floor Conference Room B of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware 19904. The Council will receive and consider input in writing from any person concerning the proposed rules and regulations. Any written comments should be submitted to the Board office in care of Gayle MacAfee at the above address. The final date to submit written comments shall be at the above scheduled public hearing. Anyone wishing to obtain a copy of the proposed rules and regulations or to make comments at the public hearing should notify Gayle MacAfee at the above address or by calling her at (302) 744-4520.

## 1770 Respiratory Care Practice Advisory Council

### *(Break in Continuity of Sections)*

#### **12.0 Sedation and analgesia regulations:**

Moderate Sedation - A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is maintained.

Direct Supervision - The physician will be present during the initial and continued administration of moderate sedation. A qualified professional capable of managing complications is present in the facility and remains in the facility until the patient is stable and complies with discharge criteria.

12.1 Certain recognized and accepted respiratory care procedures may involve the administration of sedative and analgesic medications by Respiratory Care Practitioners and the monitoring of patients who have received such medications. Such procedures include, but are not limited to:

12.1.1 Bronchoscopy

12.1.2 Nebulization of controlled substances for palliative care.

12.2 In the process of providing respiratory care, Respiratory Care Practitioners, under the direct supervision of a physician with clinical privileges to administer moderate sedation, may administer sedative and analgesic medications to induce moderate sedation, pursuant to the order of a licensed physician, who is licensed and credentialed to prescribe and administer the particular medication(s). The route of administration shall be appropriate to the procedure.

12.3 Any administration and monitoring by a Respiratory Care Practitioner of a sedative or analgesic which may induce moderate sedation must be:

12.3.1 In accordance with the current version of the "Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologist" published by the American Society of Anesthesiologists as the same may from time to time be amended with specific attention to the recommendations contained within section "Availability of an Individual Responsible for Patient Monitoring" including, but not limited to, the recommendation that:

A designated individual, other than the practitioner performing the procedure, should be present to monitor the patient throughout procedures performed with sedation/analgesia. During deep sedation, this individual should have no other responsibilities. However, during moderate sedation, this individual may assist with minor, interruptible tasks once the patient's level of sedation/analgesia and vital signs have stabilized, provided that adequate monitoring for the patient's level of sedation is maintained. (See ASA Practice Guideline No. 5.)

12.3.2 Undertaken only by Respiratory Care Practitioners who have successfully completed a formal educational experience and periodic competency assessment in the administration of sedatives, and analgesics. Such training and education shall be expressly approved for facilities accredited by a nationally recognized accrediting body approved by federal regulations in which the procedure is being performed. Such training shall include:

12.3.2.1 Competency assessment for licensed Respiratory Care Practitioners administering sedation and analgesic:

12.3.2.1.1 Successfully complete a formal dysrhythmia or EKG module or course, or the institution's approved dysrhythmia competency course.

12.3.2.1.2 Successfully complete a medication pharmacology competency specific to sedation and analgesic.

12.3.2.1.3 Current Basic Cardiac Life Support certification.

12.3.2.1.4 Completion of an institution and department specific competency related to sedation and analgesic provided by facilities accredited by a nationally recognized accrediting body approved by federal regulations.

12.3.2.1.5 Successful completion of the relevant Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) or Neonatal Resuscitation Program (NRP) course every two (2) years.

12.3.3 These periodic competencies require approval in writing by the department medical director or by another Delaware licensed physician who is in a position to assess the individual's qualifications. The Respiratory Care Practitioner must maintain his or her records of completion of the formal education and periodic

competence certification for a period of three (3) years.

12.4 Respiratory Care Practitioners may only administer sedative and analgesic substances within an acute care hospital environment or within a surgicenter owned, operated, and located on the physical property of a hospital accredited by a nationally recognized accrediting body approved by federal regulations.

### **13.0 Inhaled Anesthetic Agents**

Administration of inhaled anesthetic agents during mechanical ventilation specifically for the treatment of restrictive airway disease is limited to the emergency medicine department and/or critical care unit.

**\*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 Respiratory Care Practice Advisory Council is available at: <http://www.state.de.us/research/AdminCode/title24/1770%20Respiratory%20Care%20Practice%20Advisory%20Council.shtml#TopOfPage>**

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## DIVISION OF PROFESSIONAL REGULATION 2500 Board of Pharmacy

Statutory Authority: 24 Delaware Code, Section 2509 (24 **Del.C.** §2509)  
24 **DE Admin. Code** 2500

### PUBLIC NOTICE

The Delaware Board of Pharmacy, in accordance with 29 **Del.C.** Chapter 101 and 24 **Del.C.** §2509, proposes amendments to its regulation 2.0. Specifically, the amendments to 2.0 Grounds for Disciplinary Proceeding codify the Board's position that, in good faith and upon reasonable belief, a Pharmacist may withhold a suspected forged prescription for release to law enforcement without fear of disciplinary action by the Board. Minor grammatical, typographic, and stylistic changes are also included.

A public hearing is scheduled for Wednesday, June 20, 2007 at 10:00 a.m. in the second floor Conference Room A of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware 19904. The Board will receive and consider input in writing from any person concerning the proposed regulations. Written comments should be submitted to the Board care of Judy Letterman at the above address. The final date to submit written comments shall be at the public hearing. Anyone wishing to obtain a copy of the proposed regulations or to make comments at the public hearing should contact Judy Letterman at the above address or by calling (302) 744-4504.

The Board will consider promulgating the proposed regulations immediately following the public hearing.

### 2500 Board of Pharmacy

#### *(Break in Continuity of Sections)*

### 2.0 Grounds for Disciplinary Proceeding

2.1 ~~Unprofessional eConduct shall that may merit discipline pursuant to 24 **Del.C.** §2518(a) includes but is not limited to the following act(s) of a pharmacist pursuant to 24 **Del.C.** §2518(A):~~

2.1.1 Knowingly engaging in any activity which violates ~~S~~state and ~~F~~federal ~~Statutes~~ laws and Regulations governing the practice of ~~P~~pharmacy;

2.1.2 Knowingly dispensing an outdated or questionable product;

2.1.3 Knowingly dispensing the cheaper product and charging third party vendors for a more expensive product;

2.1.4 Knowingly charging for more dosage units than is actually dispensed;

2.1.5 Knowingly altering prescriptions or other records which the law requires the pharmacies or pharmacists to maintain;

2.1.6 Knowingly dispensing medication without proper authorization;

2.1.7 Knowingly defrauding any persons or government agency receiving pharmacy services;

# PROPOSED REGULATIONS

- 2.1.8 Placing a signature on any affidavit pertaining to any phase of the practice of pharmacy which the pharmacist knows to contain false information;
- 2.1.9 Fraudulently altering or forging the contents of prescriptions;
- 2.1.10 Payment of money or the providing of free services to a third party in return for the third party's referral of patients to the pharmacist or pharmacy;
- 2.1.11 Dispensing any legend drugs either for personal use or for use by another person without a valid order from a prescriber. Valid prescription means that it is not only written correctly, but is for a medical use (i.e. prescriptions written "as directed" are prohibited);
- 2.1.12 Unauthorized substitution;
- 2.1.13 Dispensing medications which are not approved for marketing by the Food and Drug Administration nor approved for marketing by State law;
- 2.1.14 Continuous failure to correct violations of Statutes and Regulations noted in Board of Pharmacy communication;
- 2.1.15 Knowingly allowing persons who are not registered pharmacists to dispense medication without proper supervision;
- 2.1.16 Knowingly committing a fraudulent act. This would include destroying or altering any records such as prescriptions, profiles, third party vouchers and receipts;
- 2.1.17 Knowingly misbranding a drug by using a brand name when a generic is dispensed;
- 2.1.18 Practicing under the influence of drugs or alcohol;
- 2.1.19 The placement of an advertisement which the pharmacist knows to be false or misleading;
- 2.1.20 Knowingly breaching confidentiality of the patient/pharmacist relationship by supplying information to unauthorized persons;
- 2.1.21 Engaging in activities that would discredit the profession of pharmacy;
- 2.1.22 Attempting to circumvent the patient counseling requirements or discouraging the patients from receiving patient counseling concerning their prescription drug orders; and
- 2.1.23 Using facsimile equipment to circumvent documentation, authenticity, verification, or other standards of pharmacy or drug diversion. ~~(Effective 2/29/96)~~
- 2.2 Pharmacists may, in good faith and upon reasonable belief, withhold suspected forged prescriptions for release to law enforcement at their discretion but are not required to do so. The Board will not consider disciplinary action for such an act.

## 4 DE Reg. 163 (7/1/00)

**\*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 Pharmacy is available at: <http://www.state.de.us/research/AdminCode/title24/2500%20Board%20of%20Pharmacy.shtml#TopOfPage>**

## DIVISION OF PROFESSIONAL REGULATION

### 2900 Real Estate Commission

Statutory Authority: 24 Delaware Code, Section 2905(a)(1) (24 Del.C. §2905(a)(1))

24 DE Admin. Code 2900

## PUBLIC NOTICE

The Delaware Real Estate Commission, in accordance with 24 Del.C. §2905(a)(1), has proposed changes to its Rule 8.0 of its rules and regulations to clarify and simplify the online renewal process. The revisions to Rule 8.0 also eliminate language regarding the assessment of a delinquency fee, because the Division of Professional Regulation determines all fees pursuant to 29 Del.C. §8725(c). The Commission also proposed to revise Rule 10.0 of its rules and regulations to implement the changes necessary upon the enactment of House Bill 122, with House Amendment No. 1 and Senate Amendment No. 1 of the 143rd General Assembly. Finally, the Commission

proposes to eliminate Regulation 14.0 in its entirety. Regulation 14.0 is no longer necessary because, with the enactment of Senate Bill 370 of the 143rd General Assembly, offerings of out-of-state land sales and promotions are no longer required to be registered with the Delaware Real Estate Commission.

A public hearing will be held on May 10, 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 Real Estate Commission, 861 Silver Lake Blvd., Cannon Building, Suite 203, Dover, Delaware 19904. Persons wishing to submit written comments may forward these to the Commission 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.

### **2900 Real Estate Commission**

#### ***(Break in Continuity of Sections)***

## **8.0 Renewal of Licenses**

### **8.1 Renewal Required by Expiration Date on License**

8.1.1 In order to qualify for license renewal as a real estate salesperson or broker in Delaware, a licensee shall have completed 15 hours of continuing education within the two year period immediately preceding the renewal. ~~The broker of record for the licensee seeking renewal shall certify to the Commission, on a form supplied by the Commission,~~ that the licensee has complied with the necessary continuing education requirements. This certification form shall be submitted by the licensee together with his/her renewal application and renewal fee. ~~The broker of record licensee shall retain for a period of two (2) years, the documents supporting his/her certification that the licensee he/she has complied with the continuing education requirement.~~ A licensee who has not paid the fees and/or met the requirements for the renewal of his or her license by the expiration date shown thereon, shall not list, sell, lease or negotiate for others after such date.

### **8.2 Delinquency Fee**

8.2.1 ~~If a licensee fails to renew his or her license prior to the expiration date shown thereon, he or she shall be required to pay the full license fee and an additional delinquency fee equal to one half of the license fee. If a licensee fails to renew his or her license within 60 days of the expiration date shown thereon, the license shall be cancelled.~~

8.2.2 ~~Failure to receive notice of renewal by a licensee shall not constitute a reason for reinstatement.~~

### **8.3 8.2 Reinstatement of License**

8.3.1 ~~8.2.1~~ 8.2.1 An ~~cancelled~~ expired license shall be reinstated only after the licensee pays the necessary fees, ~~including the delinquency fee,~~ and passes any examinations required by the Commission. If the licensee fails to apply for renewal within 6 months of the cancellation date, the licensee shall be required to take the state portion of the examination. If the licensee fails to apply for renewal before the next renewal period commences (two years), the licensee shall be required to pass both the state and the national portions of the examination.

8.3.2 ~~8.2.2~~ 8.2.2 No person whose license has been revoked will be considered for the issuance of a new license for a period of at least two (2) years from the date of the revocation of the license. Such person shall then fulfill the following requirements: he or she shall attend and pass the real estate course for salespersons; take and pass the Commission's examination for salespersons; and any other criteria established by the Commission. Nothing above shall be construed to allow anyone to take the course for the purpose of licensing until after the waiting period of two (2) years. Nothing contained herein shall require the Commission to issue a new license upon completion of the above mentioned requirements, as the Commission retains the right to deny any such application.

**5 DE Reg. 1387 (1/01/02)**

#### ***(Break in Continuity of Sections)***

## **10.0 Disclosure**

10.1 A licensee who is the owner, the prospective purchaser, lessor or lessee or who has any personal interest in a transaction, must disclose his or her status as a licensee to all persons with whom he or she is transacting such business, prior to the execution of any agreements and shall include on the agreement such status.

10.2 Any licensee advertising real estate for sale stating in such advertisement, "If we cannot sell your home, we will buy your home", or words to that effect, shall disclose in the original listing contract at the time he or she obtains the signature on the listing contract, the price he will pay for the property if no sales contract is executed during the term of the listing. Said licensee shall have no more than sixty (60) days to purchase and settle for the subject property upon expiration of the original listing or any extension thereof.

10.3 A licensee who has direct contact with a potential purchaser or seller shall disclose in writing whom he/she represents in any real estate negotiation or transaction. ~~The disclosure as to whom the licensee represents should be made at the 1st substantive contact to each party to the negotiation or transaction. In all cases such disclosure must be made prior to the presentation of an offer to purchase.~~ A written confirmation of disclosure shall also be included in the contract for the real estate transaction regardless of whether the relationship is a statutory agency relationship or a common law agency relationship.

10.3.1 Statutory Agency Relationships

10.3.1.1 The licensee shall provide a consumer information statement (CIS), as approved by this Commission, to the consumer no later than the first scheduled appointment or showing of a property, as required by Section 2972.

10.3.1.2 The Commission will approve a CIS which will be available on its website for use by licensees. The Commission may also approve alternative CIS's, as provided for in Section 2972(a), which also will be posted on its website. Any changes to a CIS must be approved by a quorum of the Commission.

10.3.1.3 The written confirmation of disclosure in the contract for the real estate transaction shall identify and confirm the form of statutory agency relationship.

10.3.2 Common Law Agency Relationships

10.3.2.1 The disclosure as to whom the licensee represents should be made at the 1st substantive contact to each party to the negotiation or transaction. In all cases such disclosure must be made prior to the presentation of an offer to purchase.

10.3.2.2 The written confirmation of disclosure in the contract shall be worded as follows:

10.3.2.2.1 With respect to agent for seller: "This broker, any cooperating broker, and any salesperson working with either, are representing the seller's interest and have fiduciary responsibilities to the seller, but are obligated to treat all parties with honesty. The broker, any cooperating broker, and any salesperson working with either, without breaching the fiduciary responsibilities to the seller, may, among other services, provide a potential purchaser with information about the attributes of properties and available financing, show properties, and assist in preparing an offer to purchase. The broker, any cooperating broker, and any salesperson working with either, also have the duty to respond accurately and honestly to a potential purchaser's questions and disclose material facts about properties, submit promptly all offers to purchase and offer properties without unlawful discrimination."

10.3.2.2.2 With respect to agent for buyer: "This broker, and any salesperson working for this broker, is representing the buyer's interests and has fiduciary responsibilities to the buyer, but is obligated to treat all parties with honesty. The broker, and any salesperson working for the broker, without breaching the fiduciary responsibilities to the buyer, may, among other services, provide a seller with information about the transaction. The broker, and any salesperson working for the broker, also has the duty to respond accurately and honestly to a seller's questions and disclose material facts about the transaction, submit promptly all offers to purchase through proper procedures, and serve without unlawful discrimination."

10.3.2.2.3 In the case of a transaction involving a lease in excess of 120 days, substitute the term "lessor" for the term "seller", substitute the term "lessee" for the terms "buyer" and "purchaser", and substitute the term "lease" for "purchase" as they appear above.

10.4 If a property is the subject of an agreement of sale but being left on the market for backup offers, or is the subject of an agreement of sale which contains a right of first refusal clause, the existence of such agreement must be disclosed by the listing broker to any individual who makes an appointment to see such property at the time such appointment is made.

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*(Break in Continuity of Sections)*

## **14.0 ~~Out of State Land Sales Applications~~**

~~14.1 All applications for registration of an out of state land sale must include the following:~~

~~14.1.1 A completed license application on the form provided by the Commission.~~

~~14.1.2 A \$100 filing fee made payable to the State of Delaware.~~

~~14.1.3 A valid Business License issued by the State of Delaware, Division of Revenue.~~

~~14.1.4 A signed Appointment and Agreement designating the Delaware Secretary of State as the applicant's registered agent for service of process. The form of Appointment and Agreement shall be provided by the Commission. In the case of an applicant which is a Delaware corporation, the Commission may, in lieu of the foregoing Appointment and Agreement, accept a current certificate of good standing from the Delaware Secretary of State and a letter identifying the applicant's registered agent in the State of Delaware.~~

~~14.1.5 The name and address of the applicant's resident broker in Delaware and a completed Consent of Broker form provided by the Commission. Designation of a resident broker is required for all registrations regardless of whether sales will occur in Delaware.~~

~~14.1.6 A bond on the form provided by the Commission in an amount equal to ten (10) times the amount of the required deposit.~~

~~14.1.7 Copies of any agreements or contracts to be utilized in transactions completed pursuant to the registration.~~

~~14.2 Each registration of an out of state land sale must be renewed on an annual basis. Each application for renewal must include the items identified in subsections 14.1.2 through 14.1.4 of Rule 14.0 above and a statement indicating whether there are any material changes to information provided in the initial registration. Material changes may include, but are not limited to, the change of the applicant's resident broker in Delaware; any changes to the partners, officers and directors' disclosure form included with the initial application; and any changes in the condition of title.~~

~~14.3 If, subsequent to the approval of an out of state land sales registration, the applicant adds any new lots or units or the like to the development, then the applicant must, within thirty days, amend its registration to include this material change. A new registration statement is not required, and the amount of the bond will remain the same.~~

**\*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 Delaware Real Estate Commission is available at: <http://www.state.de.us/research/AdminCode/title24/2900%20Real%20Estate%20Commission.shtml#TopOfPage>**

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## **DIVISION OF PROFESSIONAL REGULATION**

### **3300 Board of Veterinary Medicine**

Statutory Authority: 24 Delaware Code, Section 3306(a) (24 **Del.C.** §3306(a))

**24 DE Admin. Code 3300**

### **PUBLIC NOTICE**

The Board of Veterinary Medicine pursuant to 24 **Del.C.** §3306 purposes to change Professional Regulation 9.1.2 and 14.1.2. The Board will hold a public hearing on May 8, 2007. Written comments should be sent to Jennifer Myer, Administrative Assistant to the Board of Veterinary Medicine, Division of Professional Regulation, Cannon Building, 861 Silver Lake Boulevard, Suite 203, Dover, DE 19904-2467.

The proposed changes are for the purpose of allowing and facilitating online continuing education attestation.

**3300 Board of Veterinary Medicine**

*(Break in Continuity of Sections)*

**9.0 Continuing Education for Veterinarians (24 Del.C. §3309(b))**

9.1 Any veterinarian actively licensed to practice in the State of Delaware shall meet the following continuing education requirements to the satisfaction of the Board.

9.1.1 Twenty-four (24) hours of approved certified continuing education credits must be completed for the immediate two year period preceding each biennial license renewal date.

9.1.2 The number of credit hours shall be submitted to the Board with each biennial license renewal application. ~~on the proper reporting form supplied by the Board. The continuing education credit hours shall be submitted to the Board no later than 60 days prior to the biennial license renewal date. The Board may audit the continuing education credit hours submitted by a licensee.~~

9.1.2.1 Proof of continuing education is satisfied with an attestation by the licensee that he or she has satisfied the requirements of Rule 9.1.1.

9.1.2.2 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;

9.1.2.3 Licensees selected for random audit are required to supplement the attestation with attendance verification as provided in 9.1.2.4.

9.1.2.4 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.

9.1.3 A veterinarian may apply to the Board in writing for an extension of the period of time needed to complete the continuing education requirement for good cause such as illness, extended absence from the country, or unique personal hardship which is not the result of professional negligence.

9.1.4 The Board has the power to waive any part of the entire continuing education requirement. Exemptions to the continuing education requirement may be granted due to prolonged illness or other incapacity. Application for exemption shall be made in writing to the Board by the applicant for renewal and must be received by the Board no later than 60 days prior to the biennial license renewal date.

**9.2 Continuing Education Requirements for Reinstatement of Lapsed License**

9.2.1 Any veterinarian whose license to practice in the State of Delaware has lapsed and who has applied for reinstatement shall meet the following continuing education requirements to the satisfaction of the Board.

9.2.1.1 *Lapse of 12 to 24 months.* Twenty-four (24) hours of continuing education credits must be completed. The 24 hours of continuing education credits must have been completed within 2 years prior to the request for reinstatement.

9.2.1.2 *Lapse of over 24 months.* Thirty-six (36) hours of continuing education credits must be completed. The 36 hours of continuing education credits must have been completed within 4 years prior to the request for reinstatement.

**9.3 Continuing Education Requirements for Reinstatement of Inactive License**

9.3.1 Twenty-four (24) hours of continuing education credits must be submitted for licensees on the inactive roster who wish to remove their license from inactive status. The 24 hours of continuing education credits must have been completed within 2 years prior to the request for removal from inactive status.

9.4 The Board may approve continuing education courses or sponsors upon written application on Board supplied forms. In addition, the Board may approve continuing education courses or sponsors on its own motion.

9.5 The following organizations are approved for formal continuing education activities.

9.5.1 AVMA.

9.5.2 AVMA accredited schools.

9.5.3 Federal/State/County Veterinary Associations and USDA.

9.5.4 *Compendium on Continuing Education for the Practicing Veterinarian*; NOAH; VIN.

9.5.5 Registry of Approved Continuing Education (RACE) courses.

9.6 Accreditation by the Board of continuing education courses will be based upon program content. Continuing education courses shall be directed toward improvement, advancement, and extension of professional skill and knowledge relating to the practice of veterinary medicine.

9.6.1 University course work, subject to Board approval.

9.6.2 Veterinary course work completed prior to graduation may be approved for continuing education credit for the first renewal period after graduation provided the course work was completed no more than 2 1/2 years before the renewal date.

9.6.3 Government Agencies.

9.6.4 Other forms of CE as long as and the activity is approved by the Board.

9.7 The Board may at any time re-evaluate an accredited course or sponsor and withdraw future approval of a previously accredited continuing education course or sponsor.

**10 DE Reg. 884 (11/01/06)**

***(Break in Continuity of Sections)***

**14.0 Continuing Education for Veterinary Technicians (24 Del.C. §3309(b))**

14.1 Any veterinary technician actively licensed to practice in the State of Delaware shall meet the following continuing education requirements to the satisfaction of the Board.

14.1.1 Twelve (12) hours of approved certified continuing education credits must be completed for the immediate two-year period preceding each biennial license renewal date.

14.1.2 The number of credit hours shall be submitted to the Board with each biennial license renewal application on the proper reporting form supplied by the Board. ~~The continuing education credit hours shall be submitted to the Board no later than 60 days prior to the biennial license renewal date. The Board may audit the continuing education credit hours submitted by a licensee.~~

14.1.2.1 Proof of continuing education is satisfied with an attestation by the licensee that he or she has satisfied the requirements of Rule 14.1.1.

14.1.2.2 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:

14.1.2.3 Licensees selected for random audit are required to supplement the attestation with attendance verification as provided in 14.1.2.4.

14.1.2.4 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.

14.1.3 A veterinary technician may apply to the Board in writing for an extension of the period of time needed to complete the continuing education requirement for good cause such as illness, extended absence from the country, or unique personal hardship which is not the result of professional negligence.

14.1.4 The Board has the power to waive any part of the entire continuing education requirement. Exemptions to the continuing education requirement may be granted due to prolonged illness or other incapacity. Application for exemption shall be made in writing to the Board by the applicant for renewal and must be received by the Board no later than 60 days prior to the biennial license renewal date.

**14.2 Continuing Education Requirements for Reinstatement of Lapsed License**

14.2.1 Any veterinary technician whose license to practice in the State of Delaware has lapsed and who has applied for reinstatement shall meet the following continuing education requirements to the satisfaction of the Board.

14.2.1.1 *Lapse of 12 to 24 months.* Twelve (12) hours of continuing education credits must be completed. The 12 hours of continuing education credits must have been completed within 2 years prior to the request for reinstatement.

14.2.1.2 *Lapse of over 24 months.* Eighteen (18) hours of continuing education credits must be completed. The 18 hours of continuing education credits must have been completed within 4 years prior to the request for reinstatement.

**14.3 Continuing Education Requirements for Reinstatement of Inactive License**

14.3.1 Twelve (12) hours of continuing education credits must be submitted for licensees on the inactive roster who wish to remove their license from inactive status. The 12 hours of continuing education credits must have been completed within 2 years prior to the request for removal from inactive status.

14.4 The Board may approve continuing education courses or sponsors upon written application on Board supplied forms. In addition, the Board may approve continuing education courses or sponsors on its own motion.

14.5 The following organizations are approved for formal continuing education activities.

14.5.1 AVMA.

14.5.2 AVMA accredited schools.

14.5.3 Federal/State/County Veterinary Associations and USDA.

14.5.4 *The NAVTA Journal*, NAVTA-approved online continuing education

14.5.5 Registry of Approved Continuing Education (RACE) courses.

14.6 Accreditation by the Board of continuing education courses will be based upon program content. Continuing education courses shall be directed toward improvement, advancement, and extension of professional skill and knowledge relating to the practice of veterinary medicine.

14.6.1 University course work, subject to Board approval.

14.6.2 Veterinary technician program course work completed prior to graduation may be approved for continuing education credit for the first renewal period after graduation provided the course work was completed no more that 2 1/2 years before the renewal date.

14.6.3 Government Agencies.

14.6.4 Other forms of CE as long as and the activity is approved by the Board.

14.7 The Board may at any time re-evaluate an accredited course or sponsor and withdraw future approval of a previously accredited continuing education course or sponsor.

**10 DE Reg. 884 (11/01/06)**

**\*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 Veterinary Medicine is available at: <http://www.state.de.us/research/AdminCode/title24/3300%20Board%20of%20Veterinary%20Medicine.shtml#TopOfPage>**

## DIVISION OF PROFESSIONAL REGULATION

### 3700 Board of Examiners of Speech/Language Pathologists, Audiologists and Hearing Aid Dispensers

Statutory Authority: 24 Delaware Code, Section 3706(a)(1) (24 **Del.C.** §3706(a)(1))

24 **DE Admin. Code** 3700

### PUBLIC NOTICE

The Delaware Board of Examiners of Speech/Language Pathologists, Audiologists and Hearing Aid Dispensers, in accordance with 29 **Del.C.** Chapter 101 and 24 **Del.C.** §3706(a)(1), proposes amendments to its regulation 8.0 relating to the continuing education reporting period and process and the licensure renewal process. Specifically, the proposed amendments to **8.0 Continuing Education For All Licensees** provide for online license renewal, allow for attestation of continuing education (CE) compliance, push the CE completion deadline back to July 31<sup>st</sup> of renewal years, and shift the CE compliance audit from pre-renewal to post-renewal. Minor grammatical, typographic, or stylistic changes are also included.

A public hearing is scheduled for Wednesday, May 9, 2007 at 2:00 p.m. in the second floor Conference Room B of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware 19904. The Board will receive and consider input in writing from any person concerning the proposed regulations. Written comments should be submitted to the Board care of Sandra Wagner at the above address. The final date to submit written comments shall be at the public hearing. Anyone wishing to obtain a copy of the proposed regulations or to make comments at the public hearing should contact Sandra Wagner at the above address or by calling (302) 744-4532.

The Board will consider promulgating the proposed regulations immediately following the public hearing.

### 3700 Board of Examiners of Speech/Language Pathologists, Audiologists and Hearing Aid Dispensers

*(Break in Continuity of Sections)*

**8.0 Continuing Education For All Licensees:**

~~Speech/Language Pathologists, Audiologists and Hearing Aid Dispensers~~

**8.1 Philosophy**

8.1.1 Continuing education is required by the ~~Delaware Board of Examiners~~ to maintain professional licensure in the fields of Speech/Language Pathology, Audiology and Hearing Aid Dispensing. Continuing education requirements arise from an awareness that these fields are in a continual state of transition due to the introduction of new philosophies and the refinement of already existing knowledge. Speech/Language Pathologists, Audiologists and Hearing Aid Dispensers should continually strive to update their clinical skills in an effort to deliver high quality services.

8.1.2 The ~~Delaware Board of Examiners~~ is keenly aware of existing educational opportunities in Delaware and neighboring states and has established regulations which will provide continuing education credit as effortlessly as possible while assuring quality instruction. Credit will be given for participation in a variety of activities ~~which that~~ increase knowledge and enhance professional growth.

8.1.3 These regulations recognize the financial and time limitations of Delaware's professionals while assuring continued appropriate services to those individuals who require them.

**8.2 Continuing Education Criteria**

8.2.1 One continuing education contact hour is ~~abbreviated as (CE) and~~ is defined as 60 minutes of attendance/participation in an approved continuing education activity unless otherwise stated. (Therefore, credits and CEU's issued by various organizations must be translated: e.g., 1.0 ASHA CEU = 10 CE's)

8.2.2 ~~Continuing Education CE~~ Time Frame: CE requirements must be completed ~~by April 30th of in~~ each license renewal period. ~~Each licensee has up to 24 months in which to complete the minimum continuing education requirements, that is from May 1 (of the current renewal year) to April 30 of the next renewal year. Licenses expire on have until the renewal deadline, July 31st of the in odd-numbered years, to complete the required CEs.~~

8.2.3 The required number of ~~continuing education contact hours~~ CEs ~~varyies~~ with certification and/or professional status as outlined below:

8.2.3.1 New License: ~~If There is no CE requirement for a license would cover issued for less than one year, the licensee is not required, but is encouraged, to accrue continuing education hours. If a license would cover more than one year, but less than 2 years, the licensee is required to obtain 10 CE's or one-half of the required total hours.~~

8.2.3.2 Single License: Individuals ~~retaining with~~ a license in only one (1) area of specialty must obtain a minimum ~~total~~ of 20 CE's ~~for during~~ each two-year license renewal period.

8.2.3.3 Dual License: Individuals ~~retaining with~~ licenses in two (2) areas of specialty must obtain a minimum ~~total~~ of 20 CE's ~~for during~~ each two-year license renewal period, with 10 CE's obtained in each specialty area of licensure. One course may be split between specialty areas of licensure to fulfill multiple ~~continuing education CE~~ requirements. Content must be shown to be relevant to those areas.

8.2.3.4 Triple License: Individuals ~~retaining with~~ licenses in three (3) areas of specialty must obtain a minimum of 30 CE's ~~for during~~ each two-year license renewal period, with 10 CE's obtained in each specialty area of licensure. One course may be split between specialty areas of licensure to fulfill multiple ~~continuing education CE~~ requirements. Content must be shown to be relevant to those areas.

8.2.3.5 Temporary License: All ~~continuing education CE~~ requirements will be waived for temporary licensees; however, individuals are encouraged to participate in continuing education activities during their CFY period.

8.2.3.6 Extenuating Circumstances: The Board may consider a waiver of CE requirements or acceptance of partial fulfillment based on the Board's review of a written request with supporting documentation. Extenuating circumstances may include, but are not limited to, disability, illness, extended absence from the jurisdiction, and exceptional family responsibilities.

8.2.4 ~~Continuing education CE~~ courses ~~shall~~ must focus on the enhancement of clinical skills and professional growth as defined below.

8.2.4.1 Clinical Skills: conferences, workshops, courses, etc., that expand a licensee's scope of practice by enhancing skills in the areas of prevention, assessment, diagnosis, and treatment of the client (minimum of 14 CE's ~~for per~~ licensure renewal period).

8.2.4.2 Professional Growth: conferences, workshops, courses, etc., that may not directly impact on clinical services to the population being served, but are of interest to the licensee and will allow the

licensee the opportunity to stay abreast of current trends in the profession or related fields of interest (maximum of 6 CE's for per licensure renewal period).

8.2.5 Verification of attendance is may be required. Therefore, all licensees should retain documentation of their attendance at all CE activities, and allows the licensee to show the relevance of continuing education to professional practice. Excluded are any job related duties in the workplace such as staff meetings, in-service training, CPR, etc.

8.2.6 All CE activities must be approved by the Board. A licensee or CE course sponsor who wishes to be sure that an activity will be approved by the Board may request advance approval from the Board by submitting a completed Board Approval form. Approval may be requested after the conclusion of a course, but there is no guarantee the course will be approved.

8.2.7 The Board will monitor CE compliance using an with a random, post-renewal audit system. Licensees will be selected randomly for audit and notified by mail in April of each after the renewal year deadline. A licensee who is audited shall submit the Continuing Education Record. Licensees who are not audited shall retain their documentation as provided in Rule 8.4.1.2.

### 8.3 Continuing Education CE Courses/Activities

8.3.1 Continuing education CE activities sponsored by accredited related professional organizations, provided the topics are relevant to the improvement of the licensee's clinical skills or professional growth as defined in Rule 8.2.4. Verification of completion is required. Agenda of sessions attended and time spent is required for approval of convention activities.

8.3.2 A licensee may receive up to three (3) CE's for training obtained from a colleague who, after attending a professional conference, gives a formal presentation of the information from the conference after developing an agenda and outline.

8.3.3 University/College coursework for academic credit in the field of Speech/ Language Pathology, Audiology, or Hearing Aid Dispensing. Verification of credits earned upon course completion along with a A course description should must be submitted to the Board for approval. The course description may be submitted for prior approval of the course. (1 undergraduate credit = minimum of 3 CE's; 1 graduate credit = minimum of 5 CE's)

8.3.4 Professional presentations. Verification, including A presentation summary, time spent and verification from sponsor must be submitted to the Board for approval. Credit is may be given for each a presentation only once during a licensure period. (1 hour of presentation = 3 CE's)

8.3.5 Professional publication in related specialty journals. Verification required. A Reprint of the publication must be submitted to the Board for approval.

8.3.6 Other continuing education may be approved by the Board with documentation of content and hours attended.

8.3.7 Excluded are any job related duties in the workplace such as staff meetings, CPR, etc.

### 8.4 Continuing Education Licensee Responsibilities

8.4.1 All licensees shall:

8.4.1.1 Complete the required continuing education CE by April 30 July 31st of each renewal year period.

8.4.1.2 Prove completion of the CE requirement. Proof of CE requirement completion is satisfied with an attestation of completion by the licensee during the renewal process. Attestation may be completed electronically if the renewal is accomplished online at [www.dpr.delaware.gov](http://www.dpr.delaware.gov). A paper renewal that contains the attestation of completion is also acceptable. Document completed continuing education activities on the Continuing Education Record form and retain in your records for three years following renewal.

8.4.1.3 If audited, provide documentation of having attended approved continuing education CE activities as required, outlined under Rule 8.2.3 to the Board. If an activity was completed but is not approved by the Board, the licensee shall replace the CE with an approved activity before July 31 of the renewal year. A licensee who is audited shall submit documents that evidence satisfactory completion of the CE requirements for the previous two (2) years. Licensees who are not audited shall retain their documentation for three (3) years after renewal.

8.4.1.4 Mail Continuing Education Record to the Division of Professional Regulation by May 1st of the renewal year.

**6 DE Reg. 1340 (4/1/03)**

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**\*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 Speech Pathologists, Audiologists and Hearing Aid Dispensers is available at: <http://www.state.de.us/research/AdminCode/title24/3700%20Board%20of%20Examiners%20of%20Speech%20Language%20Pathologists,%20Audiologists%20&%20Hearing%20Aid%20Dispensers.shtml#TopOfPage>**

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## PUBLIC SERVICE COMMISSION

Statutory Authority: 26 Delaware Code, Section 209(a) (26 **Del.C.** §209(a))

### PUBLIC NOTICE

IN THE MATTER OF THE ADOPTION OF RULES		
CONCERNING THE IMPLEMENTATION OF 72 DEL.		
LAWS CH. 402 (2000) GRANTING THE COMMISSION		
THE JURISDICTION OF GRANT AND REVOKE THE		PSC REGULATION DOCKET NO. 51
CERTIFICATES OF PUBLIC CONVENIENCE AND		
NECESSITY FOR PUBLIC UTILITY WATER UTILITIES		
(OPENED NOVEMBER 21, 2000; REOPENED		
MARCH 20, 2007)		

### ORDER NO. 7142

This 20<sup>th</sup> day of March, 2007, the Commission determines and Orders the following:

1. In 2000, this Commission regained the authority to issue Certificates of Public Convenience and Necessity ("CPCN") to authorize entities to enter the water utility business or to allow existing water utilities to expand their operations and facilities into new service territories. See 26 **Del.C.** §203C (2006 Supp.). The Commission promulgated rules to chart how this water utility CPCN regime would work. See "Regulations Governing Water Utilities Including the Public Service Commission's Jurisdiction to Grant and Revoke Certificates of Public Convenience and Necessity" (adopted by PSC Order No. 5730 (June 5, 2001) ("2001 Rules").<sup>1</sup>

2. Under the authority granted by 26 **Del.C.** §203C(c) and 209(a), the Commission now proposes to adopt a new set of regulations related to CPCNs for water utilities. See Exhibit "B." These new Rules, entitled "Regulations Governing Certificates of Public Convenience and Necessity for Water Utilities," would supercede (and hence repeal) the 2001 Rules. They would, as did the 2001 Rules, apply to Commission-jurisdictional water utilities. Moreover, they would also govern in those instances when a governmental, municipal, or municipal authority water utility must also seek a CPCN from the Commission in order to expand its operations and facilities.<sup>2</sup>

3. In many aspects, the new rules track the form and content of the 2001 Rules. However, they include some additional matters of details, now added by Staff to respond to various administrative and practical issues that have surfaced in the water utility CPCN process since the adoption of the 2001 Rule. For example, the new rules (§§ 10.1–10.4) speak more explicitly to the content of the notifications to be sent to landowners, and how

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1. Published in 5 **DE Reg.** 212 (July 1, 2001).

2. See 26 **Del.C.** §203C(a) (2006 Supp.) (municipalities, governmental agencies, water authorities, and water districts are within the scope of water utilities required to obtain Certificates except CPCN regime not applicable where the municipal utility expands to serve within an area recently annexed by a municipality). Historically, the courts have said that when a municipal utility serves outside of its municipality's corporate boundaries, it does so in a proprietary, not governmental, capacity. See, e.g., Delmarva Enterprises, Inc. v. Mayor and Council of City of Dover, 282 A.2d 601, 602 (Del. 1971). See also Town of Smyrna v. Kent County Levy Court, 2005 WL 147933 at \*4 (Del. Super. 2005).

such notices should disclose the owner's ability to exercise the "opt-out" option provided by 26 Del.C. §203C(i) (2006 Supp.). Since 2001, the Commission has learned that while landowners value the "opt-out" option, they often are uninformed about its existence or confused as to how, and where, to exercise it. Thus, the new rules make all obligatory landowners' notices subject to Commission oversight. And the rules also rework the language to be used in explaining the "opt-out" option and require the formal notices be sent on a "stand-alone" basis, unaccompanied by other materials that the water utility may send. In a similar vein, the new rules impose particular mailing requirements related to the delivery of these notices to landowners. (§§ 9.2-9.6.) These beefed-up requirements seek to ensure that the owners have actual notice that their property will be affected by the CPCN application.<sup>3</sup>

4. At the same time, in several instances, the new rules do go beyond bureaucratic detail to address several areas that Staff suggests have skewed the water utility CPCN process. For example, sections 7.1 through 7.5 of the new rules provide definitions for the "Proposed Service Area" under each option for acquiring a CPCN. In particular, for purposes of the majority vote of the landowners' option,<sup>4</sup> the new rules cabin the new proposed service territory to either a single parcel or a group of "contiguous" parcels to be served by the same infrastructure. According to Staff, this contiguous, single system limitation will preclude the utility from crafting a disbursed service territory that utilizes the affirmative requests for water service coming in one area to then "include" – without requests – parcels located in another area. Staff asserts that this service territory limitation better comports with the original (1991) legislative intent to limit the "majority of landowners" option (§ 203C(e)(1)b.) to developments or communities where a majority of the landowners "in the area" have asked for the utility's water services.<sup>5</sup>

5. The new rules also require the applying utility to certify that it will actually provide water services to the proposed service territory within three years. (§ 3.11.) And if such certification fails to come true, the new rules then provide a mechanism for the Commission to determine whether the utility should be able to retain the CPCN in order to provide water services to the area. (§§12.1-12.6.) Again, according to Staff, this certification process dovetails with the heart of the CPCN process: to authorize a water utility to "extend[] or expand[]... its business or operations." 26 Del.C. §203C(a) (2006 Supp.) (emphasis added). In addition, Staff says, the certification's goal to ensure that service follows the CPCN is consistent with the text of §203C, which conditions the grant of a CPCN for an area on either the developer signing a "service agreement," the landowners "requesting such service," or a governmental body "requesting the applicant to provide service." (All emphasis added.) In each instance, the statutory criteria looks to water "service" in the territory, not simply the utility accumulating parcels for a large, exclusive "franchise" area.

6. The Commission now proposes to adopt the new water utility CPCN Rules. It solicits comments on any of the changes, either as to the added bureaucratic details or the new regulations related to "proposed service territory" and the "actual service" certification process. While not limiting the scope of comments, the Commission seeks input from water utilities and others on the following issues:

- (a) whether the three-year period for providing service in a new service territory is reasonable in light of water utilities' actual historical experiences;
- (b) whether there is a need to include in the new rules more specific provisions detailing who might be considered a landowner, how such land ownership might be established, and how a "majority of the landowners" option under section 203C(e)(1)b. is to be calculated; and
- (c) whether additional requirements relating to the manner or form of landowner notices should be specifically included in the new rules.

If a water utility believes the three-year period proposed for in the actual certification provision is unreasonable, the utility should provide an appropriate time frame to be utilized in that process. It should provide supporting data from its own experience to support its proffered time frame.

Now, therefore, **IT IS ORDERED:**

3. The statutory provisions of 26 Del.C. §203C(d)(1) and (e)(1) (2006 Supp.) call for delivery of notices to landowners by certified mail (or its equivalent). However, consistent with the "due process" principles articulated in Jones vs. Flowers, 547 U.S. 220 (2006), the new rules call for a follow-up mailing of notices by simple first-class mail to the landowner's best known address in instances where the earlier certified mail attempt has been returned as unsuccessful.

4. See 26 Del.C. §203C(e)(1)b. (2006 Supp.).

5. E.g., 7 Del.C. §6075 (1991) (repealed effective 2000).

1. That, for the reasons set forth in the body of this Order, and pursuant to 26 **Del.C.** §§209(a)(1) and 203C(c) and 29 **Del.C.** §10113, the Commission now proposes to repeal its "Regulations Governing Water Utilities Including the Public Service Commission's Jurisdiction to Grant and Revoke Certificates of Public Convenience and Necessity" (adopted by PSC Order No. 5730 (June 5, 2001)), and to adopt as a replacement the "Regulations Governing Certificates of Public Convenience and Necessity for Water Utilities," attached to this Order as Exhibit "B."

2. That, pursuant to 29 **Del.C.** §§1133 and 10115(a), the Secretary shall transmit to the Registrar of Regulations for publication in the Delaware Register of Regulations a copy of this Order, a copy of the current "Regulations Governing Water Utilities Including the Public Service Commission's Jurisdiction to Grant and Revoke Certificates of Public Convenience and Necessity" (Exhibit "A"), proposed to be repealed, and a copy of the now proposed "Regulations Governing Certificates of Public Convenience and Necessity for Water Utilities," (Exhibit "B").

3. That, in addition, the Secretary shall transmit the Notice of Proposed Rule-Making, attached as Exhibit "C," to the Registrar of Regulations for publication in the Delaware Register of Regulations. In addition, the Secretary shall cause such notice of Proposed Rule-Making to be published in The News Journal and the Delaware State News newspapers on two separate days before April 1, 2007. The Secretary shall include proof of such publication in the docket file before the public hearing in this matter. Further, the Secretary shall serve (by regular mail or electronic e-mail) a copy of such Notice to: (a) the Division of the Public Advocate; (b) the Department of Natural Resources and Environmental Control; (c) the State Fire Marshal; (d) the Division of Public Health; (e) the State Planning Office; and (f) each person or entity who has made a timely request for advance notice of regulation-making proceedings; (g) each water utility currently subject to the regulatory jurisdiction of the Commission; and (h) each municipal water utility, governmental water district, or municipal water and sewer authority that has previously applied for a Certificate of Public Convenience and Necessity from this Commission.

4. That, pursuant to 29 **Del.C.** §§10115(a) and 10116, persons or entities may file written comments, suggestions, compilations of data, briefs, or other written materials, on or before May 4, 2007. The Commission will conduct a public hearing on the proposed new regulations on May 16, 2007 beginning at 10:00 AM.

5. That, pursuant to 26 **Del.C.** §502 and 29 **Del.C.** §10116, Senior Hearing Examiner William F. O'Brien is designated the authority to supervise the comment period and to conduct the public hearing. Thereafter, Senior Hearing Examiner O'Brien shall organize, classify, and summarize the materials and comments and file a Report with recommendations to the Commission concerning the adoption of the new regulations. Senior Hearing Examiner O'Brien is specifically designated, under 26 **Del.C.** §102A, the power to determine the content and manner of any further public notice that might be necessary or appropriate. Senior Hearing Examiner O'Brien may also conduct further proceedings, including additional hearings, as may be necessary or appropriate.

6. That Gary A. Myers, Esquire, is designated Staff Counsel for this matter.

7. That, pursuant to 26 **Del.C.** §114, all jurisdictional water utilities are notified that they may be charged the costs of this proceeding.

8. The Commission reserves the jurisdiction and authority to enter such further Orders in this matter as may be deemed necessary or proper.

BY ORDER OF THE COMMISSION:

**NOTICE OF PROPOSED RULE-MAKING: AMENDMENT OF RULES FOR GRANTING and SUPERVISING  
CERTIFICATES OF PUBLIC CONVENIENCE AND NECESSITY FOR WATER UTILITIES**

**TO: ALL WATER UTILITIES, CONSUMERS, AND OTHER INTERESTED PERSONS**

Under 26 **Del.C.** §203C, the Public Service Commission ("PSC") holds the authority to grant a Certificate of Public Convenience and Necessity ("CPCN") to authorize an entity to begin water utility operations or to allow an existing water utility to expand its operations or business to a new proposed service territory. This CPCN authority encompasses water utilities subject to the PSC's regulation as well as municipal and other governmental water utilities, districts, or authorities. In 2001, the PSC adopted "Regulations Governing Water Utilities Including the Public Service Commission's Jurisdiction to Grant and Revoke Certificates of Public Convenience and Necessity." See 5 DE Reg. 212 (July 1, 2001). Those regulations set forth the process and criteria for reviewing, granting, or denying requests for CPCNs filed by water utilities.

Pursuant to 26 **Del.C.** §§203C(c) and 209(a), the PSC now proposes to repeal those 2001 rules and replace them with the new "Regulations Governing Certificates of Public Convenience and Necessity for Water Utilities." As outlined in PSC Order No. 7142 (Mar. 20, 2007), the PSC believes the new rules will make improvements in the administration of the CPCN process. The new rules provide for more detailed requirements for notice to affected landowners of the CPCN application and provide specific requirements on the form of notice to be sent to affected landowners to inform them of their options. The new regulations also set forth new definitions for "Proposed Service Areas" under a requested CPCN, including limiting such territories to contiguous parcels served by the same infrastructure in the case of a CPCN sought under 26 **Del.C.** §203C(e)(1)b. In addition, the new regulations add new provisions that require a water utility to certify that it will serve a new Proposed Service Area within three years and that call for a procedure to explore whether a CPCN should continue if service is not made available within such period.

You can review PSC Order No. 7142 (Mar. 20, 2007) and the proposed new rules in the April, 2007 issue of the Delaware Register of Regulations. You can also review the Order and the new regulations at the PSC's Internet website located at [www.state.de.us/delpsc](http://www.state.de.us/delpsc). Written copies of the Order and proposed regulations can be obtained at the PSC's office at the address located below, for \$0.25 per page.

The PSC now solicits comments, suggestions, compilations of data, briefs, or other written materials about the proposed repeal of the 2001 Water Utility CPCN rules and the adoption of the proposed new Water Utility CPCN rules. If you want to file any such materials, you should submit an original and ten copies of such written documents on or before May 4, 2007. You should file such materials with the PSC at the following address:

Public Service Commission  
861 Silver Lake Boulevard  
Cannon Building  
Suite 100  
Dover, Delaware, 19904  
Attn.: Reg. Dckt. No. 51

If possible, you should accompany such written comments with an electronic version of the submission. Such electronic copy may be filed on a copy-capable CD-Rom disk or send as an attachment to an Internet e-mail addressed to [Karen.nickerson@state.de.us](mailto:Karen.nickerson@state.de.us).

The PSC will also conduct a public hearing on the new proposed regulations on Wednesday, May 16, 2007. That hearing will begin at 10:00 o'clock A.M. and will be held at the PSC's office at the address set forth above. You may also submit comments and materials at such public hearing.

If you are disabled and need assistance or help to participate in the proceedings, please contact the PSC to discuss that assistance. If you want more information or have questions, you can contact the PSC about this matter at (800) 282-8574 (toll-free in Delaware) or (302) 4247 (including Text Telephone). Inquiries can also be sent by Internet e-mail addressed to [andrea.maucher@state.de.us](mailto:andrea.maucher@state.de.us).

## ~~REGULATIONS CONCERNING WATER UTILITIES INCLUDING THE PUBLIC SERVICE COMMISSION'S JURISDICTION TO GRANT AND REVOKE CERTIFICATES OF PUBLIC CONVENIENCE AND NECESSITY~~

### ~~10.101 Scope of Regulations.~~

~~These regulations are intended to govern certain practices and procedures before the Delaware Public Service Commission relating to water utilities.~~

### ~~10.102 Definitions.~~

~~As used in these regulations:~~

~~"Commission" means the Delaware Public Service Commission.~~

~~"CPCN" means a Certificate of Public Convenience and Necessity.~~

~~"DPH" means the Delaware Division of Public Health.~~

~~"DNREC" means the Delaware Department of Natural Resources and Environmental Control.~~

~~"Staff" means the Staff of the Delaware Public Service Commission.~~

~~"Secretary" means the Secretary of the Delaware Public Service Commission.~~

## ~~10-103 Application for Certificate of Public Convenience and Necessity.~~

~~(a) An application for a Certificate of Public Convenience and Necessity to begin the business of a water utility or to extend or expand the business or operations of any existing water utility shall be made in writing and filed with the Commission. The application shall include all information and supporting documentation required by statute, the Rules of Practice and Procedure of the Commission, these regulations, and shall not be considered complete until all such information and supporting documentation has been filed with the Commission. At the time of filing, the application shall:~~

~~(1) Contain a statement explaining the reason(s) why the Commission should grant the CPCN, and citations to all statutory and regulatory authority upon which the application is based, or upon which the applicant relies to support the application;~~

~~(2) Clearly state the relief sought by the application;~~

~~(3) State the name, address, telephone number, and e-mail address (if any) of the person to be notified in the event the Staff determines there are deficiencies in the application;~~

~~(4) Contain the supporting documentation required by 26 Del.C. § 203C, including evidence that all the landowners of the proposed territory have been notified of the application;~~

~~(5) Include a complete list of county tax map parcel number(s) for the area covered by the application;~~

~~(6) Include (along with a complete list of tax map number(s)) corresponding names and addresses of property owners and a copy of all tax map(s) for the area;~~

~~(7) For any proposed extension of service, contain a certification by the applicant that the extension will satisfy the provisions of 26 Del.C. § 403C, including the following:~~

~~(i) The applicant is furnishing water to its present customers or subscribers in this State in such fashion that water pressure at every house supplied is at least 25 pounds at all times at the service connection;~~

~~(ii) The applicant shall furnish water to the house or separate location of each new customer or subscriber in this State at the pressure of at least 25 pounds at each such location or house at all times at the service connection while continuing also to supply each old customer or subscriber at the pressure of at least 25 pounds at each house at all times at the service connection;~~

~~(iii) The applicant is not subject to a finding by the appropriate federal or state regulatory authority that it has materially failed to comply with applicable safe drinking water or water quality standards; and~~

~~(iv) The applicant is not subject to any Order issued by the Commission finding that the company has materially failed to provide adequate or proper safe water services to existing customers; and~~

~~(8) For applications submitted under 26 Del.C. § 203C(e), include a statement indicating whether the applicant has determined if a majority of the landowners of the proposed territory to be served object to the issuance of a CPCN to the applicant, and the documentation relied upon to support the applicant's determination.~~

~~(b) If an application for a CPCN involves a water utility project or service that requires the review, approval or authorization of any other state or federal regulatory body, including DNREC, the State Fire Marshal or DPH, the application to the Commission shall so state and shall include the following:~~

~~(1) A statement of the current status of such application;~~

~~(2) If the application to the other regulatory body or bodies has already been filed, a copy of any permit, order, certificate, or other document issued by the regulatory body relating thereto; and~~

~~(3) If such an application or amendment thereof is filed with another state or federal regulatory body or a determination is made by any such regulatory body subsequent to the date of filing the CPCN application with the Commission, but prior to its determination, a copy of any permit, order, certificate or other document that has been issued relating thereto shall be filed with the Commission.~~

~~(c) An applicant for a CPCN — other than a municipality or other governmental subdivision — shall provide with the application (if not presently on file with the Commission) the following:~~

~~(1) A corporate history including dates of incorporation, subsequent acquisitions and/or mergers;~~

~~(2) A complete description of all relationships between the applicant and its parent, subsidiaries, and affiliates. Furnish a chart or charts which depict(s) the inter-company relationships;~~

~~(3) A map identifying all areas, including all towns, cities, counties, and other government subdivisions to which service is already provided;~~

~~(4) A statement identifying any significant element of the application which, to the applicant's knowledge, represents a departure from prior decisions of the Commission;~~

~~(5) Annual reports to stockholders for applicant, its subsidiaries, and its parent for the last two years;~~

~~(6) The applicant's audited financial statements, 10K's, and all proxy material for the last two years; and~~

~~(7) Any reports submitted by the applicant within the preceding twelve months to any state or federal authorities in any proceedings wherein an issue has been raised about the applicant's failure to comply with any statute, regulation, rule, or order related to the provision of safe, adequate and reliable water service, including the water quality of water provided to existing customers.~~

~~(d) A municipality or other governmental subdivision applying for a CPCN shall provide with the application (if not presently on file with the Commission) the statement and documents identified in subsections (c)(3), (4) and (7) hereof.~~

~~(e) After a completed application has been filed and during the course of the Staff investigation of an application, the Commission may require an applicant to furnish additional information specifically related to the statutory standards for Commission review and consideration of an application, including the provision of safe, adequate, and reliable water service.~~

~~(f) Supporting documentation not filed with the application must be made available for Staff inspection upon request.~~

#### **10.104 Additional requirements for an application filed by a new water utility.**

~~(a) If the applicant for a CPCN is a new water utility that has not previously been awarded a CPCN in Delaware, the application, in addition to meeting the requirements of section 10.103, shall include the following:~~

~~(1) Evidence that it possesses the financial, operational, and managerial capacity to comply with all state and federal safe drinking requirements and that it has, or will procure, adequate supplies of water to meet demand, even in drought conditions, by maintaining supply sufficient to meet existing and reasonably anticipated future peak daily and monthly demands;~~

~~(2) A certified copy of the applicant's certificate of incorporation;~~

~~(3) Details of plant as to type, capacity, cost, status of plant construction, construction schedule, and estimated number of customers to be served; and~~

~~(4) A map showing the location and size, in acres or square feet, of the proposed territory, and the composition, diameter, length, and location of pipes to be initially installed.~~

~~(b) If the applicant for a CPCN is a new water utility that is an unincorporated proprietorship, the applicant shall be subject to a rebuttal presumption that the applicant lacks the financial, operational, and managerial capacity to comply with the requirements for a CPCN.~~

#### **10.105 Review of application; deficiencies in the application.**

~~(a) The Staff shall review all CPCN applications for compliance with applicable statutes and these regulations. The Staff will, within twenty one days after the date of filing, specifically identify any deficiencies in the application, and immediately request the Secretary to promptly notify the applicant of the alleged deficiencies. The applicant shall have thirty days from the date of the receipt of the notice from the Secretary of the deficiencies in the application to file a corrected or supplemental application. The Commission may, in its discretion, extend the period to cure deficiencies in the application for an additional thirty days.~~

~~(b) Only upon the applicant's filing of a corrected or supplemental application correcting the deficiencies shall such application be deemed completed and filed with the Commission for purposes of the time limits for action by the Commission under 26 Del. C. §203C(h). In the event the alleged deficiencies are not cured within the time provided hereunder, Staff may move the Commission to reject the utility's application for non-compliance with these regulations.~~

~~(c) Nothing in this regulation shall prevent an applicant from filing an application in draft form for Staff's informal review and comment without prejudice, such informal review and comment not to be unreasonably withheld by Staff; nor shall this regulation affect or delay the filing date of applications that comply with applicable statutes and these regulations, or whose non-compliance is deemed minor or immaterial by the Commission or its Staff.~~

#### **10.106 Filing of application with DNREC, the State Fire Marshal, and DPH; coordination and cooperation.**

~~An applicant for a CPCN shall file a copy of the application and the supporting documentation required by~~

section 10.103(a)(5) and (6) with DNREC, the State Fire Marshal, and DPH within three days of filing the same with the Commission. The Staff shall send written requests to DNREC, the State Fire Marshal, and DPH soliciting immediate written comment as to whether they are aware of any matters indicating that the applicant has been unwilling or unable to provide safe, adequate and reliable drinking water service to existing customers. The Staff shall coordinate and cooperate with DNREC, the State Fire Marshal, and DPH during the process of reviewing an application for a CPCN. The Staff shall also coordinate and cooperate with other interested state, local, and federal authorities.

#### ~~10.107 Provision of notice to all landowners of the proposed territory.~~

~~(a) Pursuant to the provisions of 26 Del.C. §203C(d)(1) and (e)(1), prior to filing the application with the Commission, the applicant shall provide written notice to all landowners of the proposed territory of the anticipated filing of the application.~~

~~(b) The written notice required by 26 Del.C. 203C(d)(1) and (e)(1) shall be sent to all landowners of the proposed territory not more than sixty days and not less than thirty days prior to the filing of the application.~~

#### ~~10.108 Landowners who object, opt out, and/or request a public hearing; time limits; extension of time.~~

~~(a) In proceedings involving an application submitted under 26 Del.C. §203C(e), any landowner whose property, or any part thereof, is located within the proposed territory to be served shall be permitted to (i) object to the issuance of the CPCN; (ii) opt out of inclusion in the territory; and/or (iii) request a public hearing. The applicant shall inform the Commission of the name and address of all landowners who notify the applicant of their objection to the issuance of the CPCN, their intention to opt out of inclusion in the territory, and/or request a public hearing, and shall file with the Commission any written notices received from such landowners. The Commission shall maintain records identifying all landowners who have provided written notice of their objection to the issuance of the CPCN, their intention to opt out of inclusion in the territory, and/or request a public hearing, and shall make such records available to the applicant.~~

~~(b) A landowner shall notify the Commission, in writing, if the landowner (i) objects to the issuance of the CPCN; (ii) intends to opt out of inclusion in the territory; and/or (iii) requests a public hearing. The notice to the Commission from the landowner must be filed with the Commission within (i) sixty days from the date of the landowner's receipt of a written notice from the water utility that complies with applicable statutes and these regulations, of the landowner's inclusion in the service territory; or (ii) thirty days of the filing of the completed application, whichever period is greater. The Commission may, in the exercise of its discretion, extend the time to object, opt out, and/or request a public hearing even though the period in which to do so has expired. The Commission shall accept for filing written notices from landowners that were sent to the applicant and transmitted by the applicant to the Commission.~~

#### ~~10.109 Notification to all landowners of the proposed territory of their rights to object, opt out, and/or request a public hearing.~~

~~(a) Pursuant to 26 Del.C. §203C(e), and for the purposes of notification to all landowners of the proposed territory encompassed by the CPCN, the notice sent to the landowners of the proposed territory must include, at a minimum, the following statement:~~

~~“(1) Pursuant to Title 26, §203C(e) of the Delaware Code, an application for a Certificate of Public Convenience and Necessity (CPCN) will be submitted to the Delaware Public Service Commission on or about {enter date of intended submission}. Your property has been included within an area {enter name of your organization} intends to serve with public water and we are required to inform you of certain information. The area to be served is {provide a shorthand description of the service area}. If you agree to the inclusion of your property in the proposed service area, no action on your part is required.~~

~~(2) Pursuant to current law, you may file an objection to receiving water service from {enter name of your organization}. Under Delaware law, the Public Service Commission cannot grant a CPCN to {enter name of your organization} for the proposed service area, including your property, if a majority of the landowners in the proposed service area object to the issuance of the CPCN. If you object to receiving water service from {enter the name of your organization}, you must notify the Commission, in writing, within sixty days of your receipt of this notice or within thirty days of the~~

~~filing of the completed application for a CPCN, whichever is greater.~~

~~(3) Pursuant to current law, you may also elect to opt out of inclusion in the proposed service area. The term "opt out" means that you decide that you do not want to receive water service from {enter name of your organization}, even if a majority of the landowners in the proposed service area do elect to receive water service from {enter name of your organization}. If you decide that you do not want to receive water service from {enter name of your organization} and instead wish to opt out, you must notify the Commission, in writing, within sixty days of your receipt of this notice or within thirty days of the filing of the completed application for a CPCN, whichever is greater.~~

~~(4) You may also request a public hearing on this matter. A request for a public hearing must be made in writing to the Commission within sixty days of your receipt of this notice or within thirty days of the filing of the completed application for a CPCN, whichever is greater.~~

~~(5) The written notice of your decision to object to the issuance of the CPCN, to opt out of receiving water service from {enter name of your organization}, and/or your written request for a public hearing, shall be sent to the Secretary of the Delaware Public Service Commission at the following address:~~

~~Secretary  
Delaware Public Service Commission  
{insert the address of the Secretary of the Delaware Public Service Commission}~~

~~(6) Any written notice you send to the Commission must include the description of the service area referred to in paragraph (1) above and the name of the applicant so the Commission will be able to identify the CPCN application to which your notice is related.~~

~~(7) Questions regarding objections, opt-outs, and hearings may be directed to: {enter the name or title, and the address and telephone number of the Commission's contact person(s)}."~~

~~(b) If a landowner sends a written notice directly to the applicant, the applicant shall file the notice with the Commission.~~

#### **~~10.110 Suspension or revocation of CPCN for good cause.~~**

~~(a) Pursuant to the provisions of 26 Del.C. § 203C(k) and (l), the Commission may suspend or revoke a CPCN, or a portion thereof, for good cause. Good cause shall consist of:~~

~~(1) A finding by the Commission of material non-compliance by the holder of a CPCN with any provisions of Titles 7, 16, or 26 of the Delaware Code dealing with obtaining water or providing water and water services to customers, or any order or rule of the Commission relating to the same; and~~

~~(2) A finding by the Commission that, to the extent practicable, service to customers will remain uninterrupted under an alternative water utility or a designated third party capable of providing adequate water service, including a trustee or receiver appointed by the Delaware Court of Chancery; and~~

~~(3) Either (i) a finding by the Commission that there are certain methods to mitigate any financial consequences to customers served by the utility subject to suspension or revocation and the adoption of a plan to implement those methods; or (ii) a finding by the Commission that there are no practicable methods to mitigate the financial consequences to customers.~~

~~(b) In addition to the factors required by section 10.110(a)(1), (2) and (3), the Commission may consider one or more of the following factors in determining whether to suspend or revoke a CPCN:~~

~~(1) Fraud, dishonesty, misrepresentation, self-dealing, managerial dereliction, or gross mismanagement on the part of the water utility; or~~

~~(2) Criminal conduct on the part of the water utility; or~~

~~(3) Actual, threatened or impending insolvency of the water utility; or~~

~~(4) Persistent, serious, substantial violations of statutes or regulations governing the water utility in addition to any finding of non-compliance required by paragraph (a)(1) above; or~~

~~(5) Failure or inability on the part of the water utility to comply with an order of any other state or federal regulatory body after the water utility has been notified of its non-compliance and given an opportunity to achieve compliance; or~~

~~(6) Such other factors as the Commission deems relevant to the determination to suspend or revoke a CPCN.~~

#### ~~10.111 Proceedings to suspend or revoke a CPCN for good cause.~~

~~(a) Proceedings before the Commission to suspend or revoke a CPCN for good cause shall be conducted in accordance with the procedures set forth in 29 Del.C. Ch. 101, Subchapter III.~~

~~(b) Unless the Commission finds, pursuant to proceedings conducted in accordance with subsection (a) above, that (i) the conduct of a water utility poses an imminent threat to the health and safety of its customers; or (ii) a water utility is unable to provide safe, adequate, and reliable water service, the Commission will not suspend or revoke a CPCN for good cause without first affording the water utility a reasonable opportunity to correct the conditions that are alleged to constitute the grounds for the suspension or revocation of the CPCN.~~

#### ~~10.112 Compliance with 29 Del. C. Ch. 101, Subchapter III.~~

~~Proceedings before the Commission involving Certificates of Public Convenience and Necessity for water utilities shall be conducted in accordance with the procedures set forth in 29 Del.C. Ch. 101, Subchapter III, including any proceedings related to any findings under 26 Del. C. § 203C(f) that an applicant is unwilling or unable to provide safe, adequate, and reliable water service to existing customers, or is currently subject to such a Commission finding.~~

#### ~~10.113 Waiver of requirements of sections 10.103 and 10.104.~~

~~The Commission may, in the exercise of its discretion, waive any of the requirements of sections 10.103 and 10.104 above.~~

## REGULATIONS CONCERNING CERTIFICATES OF PUBLIC CONVENIENCE AND NECESSITY FOR WATER UTILITIES

### 1.0 Authority and Scope of Regulations

1.1 These regulations shall govern the process: (a) for a person or entity (as described in 26 Del.C. §203C(a)) to obtain a Certificate of Public Convenience and Necessity to begin operation as a water utility; and (b) for a water utility to obtain a Certificate of Public Convenience and Necessity to extend, expand, or enlarge its operations, business, or facilities beyond its then certificated service territory. These regulations also govern, in conjunction with the provisions of 26 Del.C. §203C, how the Commission administers, supervises, and revokes any such Certificate of Public Convenience and Necessity previously granted to a water utility.

1.2 These regulations are enacted pursuant to 26 Del.C. §§203C and 209(a).

1.3 In granting, denying, or revoking a Certificate of Public Convenience and Necessity under 26 Del.C. §203C and these regulations, the Commission shall act consistently with the procedures required by 29 Del.C. ch. 101, Subchapters III and IV.

1.4 The Commission may modify or extend any of the timing requirements set forth in these regulations so long as such timing requirement is not required by statutory provision.

1.5 The Commission may by Order, and for good cause, waive any obligation under these regulations that is not required by statute and may, in an individual application, excuse any failure to comply with these regulations that is not material to the Commission's decision.

### 2.0 Definitions

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

"Commission" refers to the Public Service Commission.

"Contiguous" means that each parcel encompassed within a Proposed Service Area touches, or shares a common boundary with, at least one other parcel encompassed within the Proposed Service Area (but disregarding community open space, streets, and utility rights-of-way).

"CPCN" means a Certificate of Public Convenience and Necessity required by the provisions of 26 Del.C. §203C.

"DPH" refers to the Division of Public Health of the Department of Health and Social Services.

"DNREC" refers to the Department of Natural Resources and Environmental Control.

"Landowner notification" means the process for delivering to each landowner of record the relevant form of notice prescribed by either these regulations or further Commission directive.

"Landowners of the proposed territory to be served" shall mean such persons or entities as described and defined in 26 Del.C. §203C(j). A "landowner of record" shall refer to a single person or entity who would be encompassed within the above description and definition of "landowners of the proposed territory to be served."

"New water utility" means, for the purposes of 26 Del.C. §203C(e)(2), a water utility that has not previously provided water utility services to the public within this State.

"Postal Service" refers to the United States Postal Service.

"Proposed Service Area" is equivalent to "the proposed territory to be served" and means the area in which the applicant proposes to offer and provide its water utility services. The proposed service area shall be described by reference to one or more parcels or property, identified by the relevant county tax map identification designations. If the proposed service area cannot be described by reference to parcels of property, it may be described by a metes and bounds description, or any other equivalent description capable of being mapped.

"Record date" means the date for determining the persons and entities who are landowners of record in the Proposed Service Area. The record date shall be a date chosen by the applicant that is no more than sixty days prior to the date of filing of the application for a CPCN.

"SFM" refers to the Office of the State Fire Marshal.

"Staff" refers to the Staff of the Commission.

"Secretary" refers to the Secretary of the Commission.

"Water utility" means a person or entity as defined by 26 Del.C. §102(8) that is obligated to obtain a CPCN under 26 Del.C. §203C(a).

### **3.0 Application for Certificate of Public Convenience and Necessity**

#### In General

3.1 An application for a CPCN to begin the business of a water utility, or to extend or expand the business, operations, or facilities of any existing water utility, shall be made in writing and shall be filed with the Commission.

3.2 An applicant may request in a single application CPCNs for one to five Proposed Service Areas. In the case of an application joining multiple Proposed Service Areas, the application shall contain sufficient information and documentation to establish the grant of a CPCN for each separate Proposed Service Area. The Commission shall separately determine whether to grant a CPCN for each Proposed Service Area and may grant a CPCN for one or more of the Proposed Service Areas joined in a single application.

3.3 The CPCN application shall include all information and supporting documentation required by 26 Del. C. § 203C, the Rules of Practice and Procedure of the Commission, and these regulations. An application shall not be considered to be complete and filed until all such information and supporting documentation has been submitted to the Commission. An application shall:

3.3.1 summarize the reason(s) why the Commission should grant the CPCN for each requested Proposed Service Area;

3.3.2 provide specific citations to the statutory and regulatory provisions relied upon for a CPCN for each Proposed Service Area;

3.3.3 identify any significant element of the application that, to the applicant's knowledge, poses a unique statutory or factual question or represents a departure from prior decisions of the Commission; and

3.3.4 state the name, address, telephone number, and e-mail address of the individual to be notified concerning the contents of the application.

#### Information about each Proposed Service Area

3.4 The application shall include, for each Proposed Service Area requested:

3.4.1 a written description of the Proposed Service Area that identifies the geographic location of the Area and describes the type of area (such as an existing or proposed named development or an aggregation of a designated number of parcels);

3.4.2 a general map (reflecting towns or cities, and major transportation routes) marked to show the location of each Proposed Service Area; and

3.4.3 a listing (by county tax map parcel number or designation) of each parcel encompassed

within the Proposed Service Area, accompanied by the name and mailing addresses of the landowner(s) of record for each such parcel as of the record date.

3.4.3.1 The listing shall conspicuously identify the tax record or land record documents utilized by the applicant to determine the name and address of each landowner of record.

3.4.3.2 The listing shall conspicuously identify the record date used for determining the landowners of record of the encompassed parcels.

3.4.3.3 For requests premised on 26 Del. C. § 203C(e)(1)b., the listing shall also indicate the number of landowners of record for each parcel, and identify for each parcel which of its landowners of record have executed a petition requesting water utility services from the applicant.

3.4.3.4 For requests premised on 26 Del. C. § 203C(e)(1)b., the listing shall also indicate the applicant's calculation of the total number of landowners in the Proposed Service Area and the total number of landowners of record who have executed a petition requesting water utility services from the applicant.

#### Evidence of Landowner Notification

3.5 The application shall contain for each Proposed Service Area the documentation reflecting landowner notification as required by 26 Del. C. § 203C(d)(1) or (e)(1), including:

3.5.1 copies of relevant Postal Service forms demonstrating that the applicant sent by certified mail the appropriate form of notice as required by these regulations to each landowner of record of each parcel;

3.5.2 copies of all materials or messages provided to the applicant by the Postal Service reflecting either delivery of the certified mail or failure of certified mail delivery because the delivery was "refused," "unclaimed," "undeliverable," "unknown," or otherwise not completed; and

3.5.3 a certification (or other evidence) that, for each earlier notice that was returned by the Postal Service due to a failure of certified mail delivery, the applicant then sent another copy of the required notice by first class United States mail to the best available address of the applicable landowner of record.

#### Criteria for a CPCN Request

3.6 For a request for a Proposed Service Area premised on 26 Del. C. § 203C(d)(2)a., the application shall include all evidence (including reports or studies) that establish that the water sources and supplies then available in the Proposed Service Area do not meet the relevant standards governing drinking water for human consumption promulgated and enforced by the Department of Health and Social Services;

3.7 For a request for a Proposed Service Area premised on 26 Del. C. § 203C(d)(2)b., the application shall include all evidence (including reports or studies) demonstrating that the supply of water available to the Proposed Service Area is insufficient to meet projected demand.

3.8 For a request for a Proposed Service Area premised on 26 Del. C. § 203C(e)(1)a., the application shall include a copy of a signed service agreement with the developer of the proposed development or subdivision, and appropriate documentation reflecting that the subdivision has finally been approved by the relevant county government;

3.9 For a request for a Proposed Service Area premised on 26 Del. C. § 203C(e)(1)b., the application shall include copies of each petition requesting that the applicant provide water services signed by one or more landowners of record in the Proposed Service Area. Each such petition must meet the criteria set forth in section 8.1.

3.10 For a request for a Proposed Service Area premised on 26 Del. C. § 203C(e)(1)c., the application shall include a certified copy of the resolution or ordinance from the governing body of the relevant county or municipality that requests the applicant to provide water utility services to the Proposed Service Area. On request by the Commission, the applicant must be able to demonstrate that the county or municipality enacting the ordinance or resolution has the appropriate legal authority to direct, or request, that water utility services be provided to the Proposed Service Area.<sup>6</sup>

#### Plan of Service

3.11 An application shall include, for each Proposed Service Area, a description of how the applicant will provide water utility services to the area. In addition, the application shall include a separate certification that the applicant plans to provide its water utility services to consumers within the Proposed Service Area beginning no later than three years following the grant of a CPCN for the Area.<sup>7</sup>

#### Additional Quality of Service Certifications and Information

3.12 For requests to expand or extend water utility operations and business, the application shall contain a certification that the proposed extension and expansion will satisfy the provisions of 26 Del. C. § 403C.

The applicant shall certify that:

3.12.1 the applicant is then furnishing water to its present customers in such fashion that water pressure at every connection is at least 25 pounds at all times;

3.12.2 the applicant shall furnish water to each new customer in each Proposed Service Area at the pressure of at least 25 pounds at the service connection while continuing also to supply each existing customer at a pressure of at least 25 pounds at each service connection;

3.12.3 the applicant is not then subject to a ruling, decision, or finding by any federal or state regulatory authority that found, concluded, or determined that the application materially failed to comply with applicable safe drinking water or water quality standards; and

3.12.4 the applicant is not subject to any finding or Order of the Commission that determined that the applicant materially failed to provide adequate or proper safe water services to existing customers.

3.13 If an applicant cannot supply each of the above certification, the application shall include a statement why the applicant cannot provide such certification or why the provisions of 26 Del. C. § 403C do not apply to the applicant or application.

3.14 If an application will involve a water utility project or water utility services that require the review, approval or authorization of any other state or federal regulatory body (including DNREC, the SFM, or the DPH) the application shall also include:

3.14.1 a description of the nature of the review by the other agency and the current status of such review; and

3.14.2 copies of any permit, order, certificate, approval, or other documents already issued by the regulatory body relating to the water project or services.

3.15 If, after the filing of the application, any other state or federal regulatory body issues any permit, order, certificate, approval, or other documents related to the water project or services relevant to the application, the applicant shall promptly file such document with the Commission.

Additional Materials to be Supplied with the Application

3.16 If not already on file with, or available to, the Commission, an applicant - other than a municipal or other governmental water utility - shall provide with the application the following information:

3.16.1 a corporate or business history including dates of incorporation and subsequent acquisitions and/or mergers;

3.16.2 a complete description of all relationships between the applicant and its parent, subsidiaries, and affiliates, including a chart of such intra- and inter-company relationships.

3.16.3 a map identifying all areas where the applicant then provides water utility services;

3.16.4 the Annual Reports provided to owners of the applicant, or to the owners of its parent or subsidiaries, over the two-year period prior to the filing of the application;

3.16.5 the audited financial statements, SEC 10K filings, and all proxy material related to the applicant for the two years prior to the filing of the application; and

3.16.6 copies of all reports submitted by the applicant within the preceding twelve months to any State or federal authority related to whether the applicant has complied with any statute, regulation, rule, or order concerning the provision of safe, adequate, and reliable water services (including the quality of water provided to existing customers).

3.17 If not already on file with the Commission, a municipal or other governmental water utility shall provide with the application the statement and documents identified in sections 3.16.3 and 3.16.6.

6. In the case of an ordinance or resolution by a municipality, the Commission will presume, subject to rebuttal, that the municipality lacks the legal authority to direct or request a water utility, including a municipal or other governmental water utility, to provide water utility services to a Proposed Service Area (or portions of such area) that lie outside the municipality's corporate boundaries. The applicant, or municipality, may present in the application evidence and argument to rebut this presumption. In the absence of such a rebuttal, the applicant must provide materials to justify a CPCN for such Proposed Service Area premised on a ground other than 26 Del.C. § 203C(e)(1)c.

7. This requirement shall not apply to a municipal water utility or a government water utility serving an area in its governmental (and not proprietary) capacity.

## **4.0 Additional Requirements for an Application Filed by a New Water Utility**

4.1 If the applicant is a new water utility, the application, in addition to fulfilling the requirements of sections 3.0 through 3.17, shall also include the following:

4.1.1 a copy of the applicant's certificate of incorporation, partnership agreement, or other enabling document;<sup>8</sup>

4.1.2 evidence to demonstrate that the applicant possesses the financial, operational, and managerial capacity to comply with all State and federal safe drinking requirements and that the applicant has available, or will be able to procure, an adequate supply of water (even during drought conditions) to meet reasonably anticipated peak daily and monthly demands for its water utility services;

4.1.3 a description of the plant to be utilized to provide its water utility services (including details as to the type and capacity of treatment facilities, cost of facilities, and the projected construction schedule);

4.1.4 a map detailing the composition, diameter, length, and location of mains and pipes to be initially installed; and

4.1.5 a projection of the number of customers to be served in the five-year period following the grant of the requested CPCN.

## **5.0 Review of the Application and Deficiencies in the Application**

5.1 An applicant may ask the Staff to informally review a draft application prior to its filing. Such informal review shall not affect or delay the filing of an application that complies with applicable statutes and these regulations.

5.2 Upon filing, the Staff shall review an application for compliance with the applicable statutory provisions and these regulations. Within thirty days after the date of filing, Staff may notify the applicant of specific deficiencies in the application. The applicant shall have thirty days from the date of the receipt of such notice to file an amended or supplemental application. The Commission may, in its discretion, extend the period for curing deficiencies in the application for an additional period of time.

5.3 If the applicant submits an amended or supplemental application, the application shall then be deemed filed on the date of such submission for the purposes of the time limits set forth in 26 Del.C. §203C(h). In the event the deficiencies identified by Staff are not cured within the time period provided, Staff may request the Commission to reject the application.

5.4 During the period the application is pending before the Commission, the Staff may request the applicant to provide additional relevant information or documents.

## **6.0 Coordination with Other State Agencies, Counties, and Municipalities**

6.1 At the time of the filing of an application, or within three days thereafter, the applicant shall serve copies of its application on DNREC, the SFM, and the DPH.

6.2 In addition, if any parcel of land in a Proposed Service Area is located within a "future annexation area" or "future growth area" under a comprehensive plan (26 Del.C. §§101 and 702) adopted by a municipality that provides water utility services, then the applicant shall also serve a copy of the application on the municipality (or its municipal utility). The applicant shall serve such copy on the municipality (or its utility) at least thirty days prior to filing the application with the Commission. The application filed with the Commission shall include a certification of such service on the identified municipality.

6.3 The Staff shall coordinate and cooperate with DNREC, the SFM, and the DPH during the process of reviewing an application for a CPCN. Staff may also coordinate and cooperate with other interested State, local, and federal authorities in reviewing the request for a CPCN.

## **7.0 Proposed Service Area**

7.1 For a request premised on 26 Del.C. §203C(d)(2)a., the Proposed Service Area shall encompass

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8. If the business structure of the applicant is a sole proprietorship, the Commission will presume, subject to rebuttal, that the applicant lacks the financial, operational, and managerial capabilities to provide adequate water utility services. An applicant that is a sole proprietorship may provide with the application evidence to rebut this presumption and demonstrate that it will have the capabilities to provide such adequate and reliable services.

# PROPOSED REGULATIONS

only such parcels of land that lack available water sources or supplies that meet the standards governing drinking water for human consumption promulgated and enforced by the Department of Health and Social Services.

7.2 For a request premised on 26 Del.C. §203C(d)(2)b., the Proposed Service Area shall encompass only such parcels of land that lack available water sources or supplies sufficient to meet the projected demand for water in such parcels.

7.3 For a request premised on 26 Del.C. §203C(e)(1)a., the Proposed Service Area shall encompass only such parcels that are within the subdivision or development plat or plan that has been finally approved by the relevant county government.

7.4 For a request premised on 26 Del.C. §203C(e)(1)b., the Proposed Service Area shall encompass either:

7.4.1 a single parcel; or

7.4.2 two or more contiguous parcels that will be provided water utility services by the same stand-alone system or by the same main extension.<sup>9</sup>

7.5 For a request premised on 26 Del.C. §203C(e)(1)c., the Proposed Service Area shall encompass only such parcels of land that the governing body of the county or municipality has directed, requested, or authorized the applicant to serve.

## **8.0 Requirements Related to 26 Del.C. §203C(e)(1)b.**

8.1 For a request premised on 26 Del.C. §203C(e)(1)b., each petition requesting water service from the applicant must:

8.1.1 bear the signature of each landowner of record (or a duly authorized agent) that requests water service from the applicant;

8.1.2 reflect the date for each signature by a landowner of record, which date shall not be any earlier than one year prior to the date of the filing of the application;

8.1.3 bear a printed recitation of the name of each landowner of record executing the petition;

8.1.4 describe the nature and office of the executing individual if the request is by an artificial entity;

8.1.5 identify the tax map parcel number associated with each landowner of record requesting water service; and

8.1.6 list the present mailing address and telephone number of each landowner of record that requests water service.

8.2 If a petition under 26 Del.C. §203C(e)(1)b. involves a petition for water service on behalf of condominium units as defined by 26 Del.C. §203C(j), the applicant shall provide with such petition the materials required by 26 Del.C. § 203C(g)(1).

8.3 If a petition for water service is executed by an agent of the landowner of record, the applicant shall provide with the petition evidence to demonstrate the agent's authority to act for the landowner of record.

## **9.0 Notice to Landowners in the Proposed Service Area**

9.1 Pursuant to the provisions of 26 Del.C. §203C(d)(1) and (e)(1), prior to filing the application, the applicant shall send the form of notice prescribed by these regulations to each landowner of record in the Proposed Service Area. The landowners of record shall be determined as of the record date.

9.2 The form of notice required by these regulations shall be sent to each landowner of record not more than sixty days and not less than thirty days prior to the filing of the application.

9.3 For requests premised on 26 Del.C. §203C(d)(2)a. or b., the notices shall be sent by United States certified mail, return receipt requested, with delivery restricted to the addressee.

9.4 For requests premised on 26 Del.C. §203C(e)(1)a. or c., the notices shall be sent by United States certified mail, return receipt requested, with delivery restricted to the addressee.

9.5 For requests premised on 26 Del.C. §203C(e)(1)b., the notices shall be sent to those landowners of record who did not execute a petition for water services by United States certified mail, return receipt requested.

9. If a landowner of record removes a contiguous property from the Proposed Service Area by the exercise of the "opt-out" option available under 26 Del.C. §203C(i), the exclusion of the parcel shall not render the remaining parcels non-contiguous.

and with delivery restricted to the addressee. In the case of landowners of record who did execute petitions for water service, the notices shall be sent by United States certified mail, return receipt requested.

9.6 If the Postal Service returns to the applicant any materials reflecting that, in the case of a particular landowner of record, the certified mail delivery required under sections 9.3 through 9.5 failed because the delivery was "refused," "unclaimed," "undeliverable," "unknown," or otherwise not completed, then the applicant shall promptly re-send the form of the required notice by first class United States mail to the best available address of that landowner of record.

9.7 The Commission, by Order, may authorize a method of providing notice to landowners of record that is equivalent to the methods set forth in sections 9.3 through 9.6.

## **10.0 Form of Notice to Landowners of Record**

10.1 The notice to be sent to landowners of record in a request premised on either 26 Del.C. §203C(d)(2), 26 Del.C. §203C(e)(1)a., or 26 Del.C. §203C(e)(1)c. shall be in a form approved by Staff.

10.2 If the request is premised on 26 Del.C. §203C(e)(1)b., the form of notice sent to landowners of record must include the following statements:

"Public records list you as a landowner of the property with the following tax map parcel identification number(s): *[insert tax map parcel identification number(s)]*. Within sixty (60) days, *[insert water company's name]* plans to file an application with the Delaware Public Service Commission ("PSC") requesting a Certificate Of Public Convenience and Necessity ("CPCN") to provide water services to an area described as *[insert description of proposed service area]*. *[INSERT WATER COMPANY'S NAME]* HAS INCLUDED YOUR PROPERTY IN THE AREA IT INTENDS TO SERVE. IF YOU DO NOT TAKE ANY ACTION NOW, YOU MAY LOSE YOUR CHOICE OF WHO CAN PROVIDE WATER SERVICE TO YOUR PROPERTY AND WHETHER YOU CAN OBTAIN A WELL PERMIT. You should read this notice carefully to understand the options you have under the law in this situation.

a) You may choose to remain in the utility's proposed service territory. If you signed a petition for water services and wish to remain in the utility's proposed service territory, or, if you did not sign a petition for water services but do not object to being included, you may do nothing and disregard this letter.

(b) You may choose to "opt-out" of the utility's proposed service territory. You have the right to "opt-out" and have your property removed from the utility's service area. You can do this even though others in your area might desire water service from the utility. You should understand that being included in a utility's service area does not mean that public water services will be immediately available to your property or that, when available, you will be required to hook-up to the public water system. However, if your property is included in the utility's water service territory and the well serving your drinking water needs becomes unusable, the Department of Natural Resources and Environmental Control might deny you a permit for a new well if there is public water available to your property. On the other hand, if you elect to "opt-out" of the utility's service area, but later change your mind and decide to connect to the utility's public water system, you could be charged additional fees to be included in a new CPCN service area. Finally, you cannot "opt-out" after the Commission has granted the CPCN to the utility.

(c) You may object to the Commission granting a CPCN for the proposed service territory. You can also file an objection to the utility's application. If a majority of the landowners in the utility's proposed service territory object to the utility providing water services, the PSC might deny the utility the right to serve in such area. An objection does not remove your property from the service territory; it simply reflects that you do not want the utility to provide services in the area. If you want to make sure your property is not included in the utility's service territory, you should file the "opt-out" request described above.

(d) You may request a public hearing on the CPCN application. You can also request that the PSC hold a public hearing on the utility's request for a CPCN to serve the proposed service territory. At the hearing, you can show that the utility has not met the legal requirements for obtaining a CPCN to serve in the area. You should review the law about what a utility must provide in order to obtain a CPCN (contact the PSC to obtain a copy of the law). If you request a hearing,

you will need to tell the PSC why the utility has not met the law's requirements for a CPCN. Again, a request for a hearing will not remove your property from a proposed service area. To remove your property from the service territory, you must request to "opt-out."

Under the law, the PSC is obligated to grant a CPCN to a utility to provide water services if a majority of the landowners in a proposed service area have requested the utility's water services. This means that even if you have not signed a request for the utility's water services, your property may be included in the utility's service area if more than half of the landowners have made such requests. However, if you do not want your property included in the utility's proposed service territory or if you oppose the utility providing services in the area, then you must do something under one or more of the above options within 60 days. Attached to this letter is a form which allows you (and other owners of the property) to exercise one or more of the options. If you wish to exercise any of the options, complete the form and return it to the PSC at the address listed below within 60 days from the date you receive this notice:

Delaware Public Service Commission  
861 Silver Lake Boulevard  
Cannon Building, Suite 100  
Dover, Delaware 19904

If you have any questions, comments or concerns, please contact the PSC at (302) 739-4247 (in Delaware, call 800-282-8574) or by Internet e-mail at [delpsc@state.de.us](mailto:delpsc@state.de.us)."

10.3 In a request under 26 Del.C. §203C(e), the notice sent to each landowner shall also include a form of response (in a form approved by Staff) that allows the landowner to easily and plainly exercise the options available under the form of notice.

10.4 Except as the Commission might specifically approve, the applicant shall not include any other correspondence with the landowner notice required by these regulations. The exterior of the envelope for any notice shall carry language (approved by Staff) to alert the landowner of the importance of the notice.

10.5 Within twenty-one days of the filing of the application, the applicant shall also publish in two newspapers of general circulation a form of public notice of its application. The Staff shall approve a form of such public notice. The applicant shall promptly file proof of such publication with the Commission.

#### **11.0 Landowner's Options to Object, "Opt-Out," and Request a Public Hearing**

11.1 In a request premised under 26 Del.C. §203C(e), a landowner of record of a parcel that is, in whole or in part, within a Proposed Service Area may: (a) object to the issuance of the CPCN; (b) request a hearing to challenge whether the applicant has satisfied the requirements for a CPCN; or (c) "opt-out" and have the landowner's parcel excluded from the Proposed Service Area under 26 Del.C. §203C(i). A landowner of record may exercise one or more of the above options.

11.1.1 The applicant shall immediately inform the Commission of the name and address of each landowner of record that notifies the applicant, either verbally or in writing, that the landowner wishes to exercise any one of the options under section 11.1. The applicant shall immediately file with the Commission any written documents from a landowner that exercises any of the options in section 11.1.

11.2 A landowner of record may object to the CPCN or request a hearing on the application by filing with the Commission a signed written document reflecting such request. Such document shall be filed within thirty days after the filing of the application.

11.3 At any time prior to the issuance of the CPCN, a landowner of record may file with the Commission a signed written document requesting that the landowner's parcel be excluded from the Proposed Service Area under 26 Del.C. §203C(i). A parcel will be excluded from the Proposed Service Area if any landowner of record of such parcel submits a signed "opt-out" request for exclusion of the parcel. The Commission may deny an "opt-out" request submitted by a landowner of record if the remaining landowners of record of the same parcel object to the exclusion and demonstrate that they hold the power to bind the parcel.

11.4 The Commission shall maintain a record of all written documents received from landowners of record that exercise the options available under section 11.1 through 11.3.

11.5 For good cause, the Commission may allow persons or entities that are not landowners of record to file a request for a hearing on an application.

## **12.0 Conditional Grant of a CPCN for a Proposed Service Area**

12.1 A CPCN to provide water utility services to a Proposed Service Area shall be conditional on the applicant subsequently providing actual water utility services to consumers within the Area within three years from the grant of the CPCN, consistent with the certification under section 3.11.

12.2 If at the end of three years after the grant of a CPCN the water utility is not providing actual water services to consumers within the Service Area granted by the CPCN, the Commission may institute a proceeding to determine whether the previously granted CPCN should lapse because of the water utility's failure to provide water utility services.

12.3 In determining whether the previously granted CPCN should lapse, the Commission may consider: (a) whether the landowners of record in the Service Area continue to endorse the water utility providing water utility services to their properties; (b) whether the utility has a reasonable plan to begin to provide water utility services in the near future; and (c) whether the Service Area supports, or is essential to, the water utility providing water services to another Service Area.

12.4 If the Commission determines that the previously granted CPCN should lapse, any water utility may then file an application for a CPCN to provide water utility services to one or more parcels encompassed by the lapsed CPCN.

12.5 A water utility granted a CPCN shall, within three years of the date of the CPCN, file a notice with the Commission reporting the date that it actually began providing water utility services to consumers in each Service Area granted by the CPCN.

12.6 The provisions of sections 12.1 through 12.5 shall not apply to a CPCN granted to a municipal water utility or a government water utility to provide water utility services to a service area in its governmental capacity. In addition, those provisions shall not apply to any Service Area granted under 26 Del.C. §203C(e)(1)c. to a non-municipal or non-governmental water utility unless the relevant governing board of the municipality or county has withdrawn or revoked its earlier request for the water utility to provide its water utility services to the Service Area.

## **13.0 Suspension or Revocation of CPCN for Good Cause**

13.1 Pursuant to the provisions of 26 Del.C. §203C(k) and (l), the Commission may suspend or revoke a CPCN, or a portion thereof, for good cause. Good cause shall consist of:

13.1.1 a finding by the Commission that the holder of a CPCN has not materially complied with: (a) any provisions of Titles 7, 16, or 26 of the Delaware Code dealing with obtaining water or providing water and water services to customers; or (b) any order or rule of the Commission relating to the same;

13.1.2 a finding by the Commission that, to the extent practicable, service to customers will remain uninterrupted under an alternative water utility or a designated third party capable of providing adequate water service, including a trustee or receiver appointed by the Delaware Court of Chancery; and

13.1.3 either (a) a finding by the Commission that there are certain methods to mitigate any financial consequences to customers served by the utility subject to suspension or revocation and the adoption of a plan to implement those methods; or (b) a finding by the Commission that there are no practicable methods to mitigate the financial consequences to customers.

13.2 The Commission may also consider one or more of the following factors in determining whether to suspend or revoke a CPCN:

13.2.1 fraud, dishonesty, misrepresentation, self-dealing, managerial dereliction, or gross mismanagement on the part of the water utility; or

13.2.2 criminal conduct on the part of the water utility; or

13.2.3 actual, threatened or impending insolvency of the water utility; or

13.2.4 persistent, serious, substantial violations of statutes or regulations governing the water utility in addition to any finding of non-compliance required by section 13.1.1 above; or

13.2.5 failure or inability on the part of the water utility to comply with an order of any other State or federal regulatory body after the water utility has been notified of its non-compliance and given an opportunity to achieve compliance; or

13.2.6 such other factors as the Commission deems relevant to the determination to suspend or

revoke a CPCN.

**14.0 Proceedings to Suspend or Revoke a CPCN for Good Cause**

14.1 Proceedings before the Commission to suspend or revoke a CPCN for good cause shall be conducted in accordance with the procedures set forth in 29 Del.C. ch. 101, Subchapters III and IV.

14.2 Unless the Commission finds, pursuant to proceedings conducted in accordance with section 14.1 above, that (a) the conduct of the water utility poses an imminent threat to the health and safety of its customers; or (b) the water utility is incapable of providing safe, adequate, and reliable water service, the Commission will not suspend or revoke a CPCN for good cause without initially affording the water utility a reasonable opportunity to correct the conditions that are alleged to constitute the grounds for the suspension or revocation of the CPCN.

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**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.

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**DEPARTMENT OF AGRICULTURE  
THOROUGHBRED RACING COMMISSION**

Statutory Authority: 3 Delaware Code, Section 10005; (3 **Del.C.** §10005)  
3 DE Admin. Code 1001

**ORDER**

Pursuant to 29 **Del.C.** §10118 and 3 **Del.C.** §10103, the Delaware Thoroughbred Racing Commission issues this Order adopting proposed amendments to the Commission's Rules. Following notice and a public hearing on February 27, 2007, the Commission makes the following findings and conclusions:

**SUMMARY OF THE EVIDENCE**

1. The Commission posted public notice of the proposed amendments in the January 1, 2007 in the *Register of Regulations* and for two consecutive weeks in *The News Journal* and *Delaware State News*. The Commission proposed to update:

- Rule 6.0 to better describe license structure and requirements.
- Rule 11.1.1 to require eligibility at the time of entry and starting of a race; and
- Rule 15 to clarify policy and procedure surrounding the use, testing and penalty for prohibited substances and impermissible levels of acceptable substances.

2. The Commission received no written comments during January 2007. The Commission held a public hearing on February 27, 2007 and received public comments:

**Regarding Rule 6**

from Fritz Burkhardt, Steward. Mr. Burkhardt stated that he believes that this rule change is necessary in order to prevent persons who are not supposed to own horses from owning them. In addition, Mr.

Burkhardt stated that it is important to ensure that owners are licensed and to eliminate hidden ownership as much as possible. He believes that this rule change will help facilitate that.

**Regarding Rule 11**

from Fritz Burkhardt, Steward and William Fasy, Chief Operating Officer, Delaware Park.

a. Mr. Burkhardt stated that he believes that this rule change is necessary in order to prevent persons, for example, from entering a horse in Maryland in a maiden race, and then coming to Delaware and doing the same. In addition, Mr. Burkhardt felt that as this issue has arisen from time to time, it is important for the Commission to clarify its position on the matter.

b. Mr. Fasy stated that this rule will make this situation much easier to deal with.

**Regarding Rule 15**

from Fritz Burkhardt, Steward; William Fasy, Chief Operating Officer, Delaware Park; Bessie Gruwell, DTHA, Executive Director; Joseph Strug, Dalare Associates, Lab Director; and Dr. John T. Peters, Supervising Commission Veterinarian. In addition, John Wayne, Administrator of the Delaware Thoroughbred Racing Commission, pointed out two typographical errors in the proposed changes to Rule 15. In both proposed Rule 15.12.1.1 and Rule 15.12.1.5, the word "driver" should read "rider." The public comments are reflected below:

a. Mr. Burkhardt stated that the penalties reflected in the proposed change to 15.1.3.1.5 are more appropriate. He hears many complaints from trainers that it makes no sense to have a \$500.00 fine for a Lasix violation but only \$250.00 for a Bute violation. As to the changes adding specific EPO/DPO penalty language, Mr. Burkhardt stated that horses can be in limbo for awhile, pending the receipt of split sample results. He also stated that purse monies are held awhile in abeyance until these cases are worked out as well.

b. Ms. Gruwell agreed with Mr. Burkhardt and stated that a medication violation should be treated differently than a prohibited substance. The perception of the trainers is that the prohibited substances should receive a harsher penalty.

c. Dr. Peters stated that it is true that it takes time to receive the results of a split sample back. It can be two weeks before the secondary sample can even be sent out for a confirmatory test.

d. Mr. Strug clarified the process of EPO testing. He stated that it takes a while to receive results on split samples. A screening test only is done at the track. Then the sample is sent out to a laboratory that performs in EPO/DPO confirmatory tests. There are currently only two labs that do so, but more are expected soon. EPO testing is handled much differently than regular testing. Also, this new EPO test can only find EPO or DPO for up to 72 hours after administration to the horse. Therefore, it will be possible to tell who is responsible.

e. Mr. Fasy stated that he believes it is prudent to have the split sample come back before the Stewards hold their hearing. He recognizes that sometimes this may continue into the next meet, but that the Stewards will hold the purses in the meantime.

**FINDINGS OF FACT AND CONCLUSIONS**

3. The public was given notice and an opportunity to provide the Commission with comments in writing and by testimony at the public hearing on the proposed amendments to the Commission's Rules.

4. In light of the lack of written comment on the rule changes as proposed, and the public comment in favor of the changes:

**Regarding Rule 6**

to Rule 6, the Commission hereby adopts the rule changes as proposed. The Commission believes that this rule change will help the Delaware Thoroughbred Racing Commission rules to be more consistent with our surrounding states surrounding hidden ownership

**Regarding Rule 11**

to Rule 11.1.1, the Commission hereby adopts the rule changes as proposed. The Commission believes that this rule change will help clarify the Delaware Thoroughbred Racing Commission rules and make them more consistent with our surrounding states' racing rules.

## Regarding Rule 15

to Rule 15, the Commission hereby adopts the rule changes as proposed, with the exception of two typographical errors. (In both proposed Rule 15.12.1.1 and Rule 15.12.1.5, the word "driver" will be changed to "rider.").

The Commission believes that these rule changes will stress the Delaware Thoroughbred Racing Commission's harsh view of blood doping of horses in making the penalties more severe for EPO and DPO violations. This will send a serious message that the use of these substances will not be tolerated by the Commission. Hopefully, the increased penalties will act as a deterrent to using these substances. In addition, the change to rule 15.10.6.9 is important in that it was an issue in a recent appeal. This change updates the language from an outdated collection container formerly used in testing.

The effective date of this Order will be ten (10) days from the publication of this Order in the *Register of Regulations* on April 1, 2007.

**IT IS SO ORDERED** this 27th day of March, 2007.

### **Thoroughbred Racing Commission**

Bernard J. Daney, Chairman

Debbie Killeen, Commissioner

Edward J. Stegemeier, Commissioner

W. Duncan Patterson, Secretary

H. James Decker, Commissioner

\* Please note that no changes made to the regulation as originally proposed and published in the January 2007 issue of the *Register* at page 1086 (10 DE Reg. 1086). Therefore, the final regulation is not being republished in its entirety. Please refer to the January 2007 issue of the *Register* or contact the Thoroughbred Racing Commission for more information.

A complete set of the rules and regulations for the Thoroughbred Racing Commission are available at: <http://www.state.de.us/research/AdminCode/title3/index.shtml>

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## **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

### **REGULATORY IMPLEMENTING ORDER**

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

##### **I. Summary of the Evidence and Information Submitted**

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.

Notice of the proposed regulation was published in the *News Journal* and the *Delaware State News* on Thursday January 18, 2007, in the form hereto attached as Exhibit "A". Comments were received from Governor's Advisory Council for Exceptional Children and the State Council for Persons with Disabilities. The Councils asked why there was no reference to the charter schools in this regulation requiring curriculum alignment with the content

standards. Charter schools are required to align their curriculum with the state content standards in the Charter School regulation 14 **DE Admin. Code** 275.4.3.1.

## II. Findings of Facts

The Secretary finds that it is appropriate 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.

## III. Decision to Amend the Regulation

For the foregoing reasons, the Secretary concludes that it is appropriate to amend 14 **DE Admin. Code** 502. Therefore, pursuant to 14 **Del.C.** §122 (6), 14 **DE Admin. Code** 502 attached hereto as Exhibit "B" is hereby amended. Pursuant to the provision of 14 **Del.C.** §122(e), 14 **DE Admin. Code** 502 hereby amended shall be in effect for a period of five years from the effective date of this order as set forth in Section V. below.

## IV. Text and Citation

The text of 14 **DE Admin. Code** 502 amended hereby shall be in the form attached hereto as Exhibit "B", and said regulation shall be cited as 14 **DE Admin. Code** 502 in the Administrative Code of Regulations for the Department of Education.

## V. Effective Date of Order

The actions hereinabove referred to were taken by the Secretary pursuant to 14 **Del.C.** §122 on March 7, 2007. The effective date of this Order shall be ten (10) days from the date this Order is published in the *Delaware Register of Regulations*.

**IT IS SO ORDERED** the 7th day of March 2007.

### Department of Education

Valerie A. Woodruff, Secretary of Education

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

### 1.0 Purpose

[1.1] 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 Simulative 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**

**[3.1]** 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**

**[4.1]** 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 desegregated 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

[7.1] 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

[8.1] 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

## REGULATORY IMPLEMENTING ORDER

### 540 Driver Education

#### I. Summary of the Evidence and Information Submitted

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.

Notice of the proposed regulation was published in the *News Journal* and the *Delaware State News* on Thursday January 18, 2007, in the form hereto attached as Exhibit "A". Comments received from Governor's Advisory Council for Exceptional Children and the State Council for Persons with Disabilities endorsed the amended regulation.

#### II. Findings of Facts

The Secretary finds that it is appropriate to amend 14 **DE Admin. Code** 540 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.

#### III. Decision to Amend the Regulation

For the foregoing reasons, the Secretary concludes that it is appropriate to amend 14 **DE Admin. Code** 540. Therefore, pursuant to 14 **Del.C.** §122, 14 **DE Admin. Code** 540 attached hereto as Exhibit "B" is hereby amended. Pursuant to the provision of 14 **Del.C.** §122(e), 14 **DE Admin. Code** 504 hereby amended shall be in effect for a period of five years from the effective date of this order as set forth in Section V. below.

#### IV. Text and Citation

The text of 14 **DE Admin. Code** 540 amended hereby shall be in the form attached hereto as Exhibit "B", and said regulation shall be cited as 14 **DE Admin. Code** 540 in the *Administrative Code of Regulations* for the Department of Education.

#### V. Effective Date of Order

The actions hereinabove referred to were taken by the Secretary pursuant to 14 **Del.C.** §122 on March 15, 2007. The effective date of this Order shall be ten (10) days from the date this Order is published in the *Delaware Register of Regulations*.

**IT IS SO ORDERED** the 15th day of March 2007.

#### Department of Education

Valerie A. Woodruff, Secretary of Education

Approved this 15th day of March 2007

#### State Board of Education

Jean W. Allen, President

Richard M. Farmer, Jr., Vice President

Mary B. Graham, Esquire  
Barbara Rutt  
Dr. Claibourne D. Smith

Gregory A. Hastings  
Dennis J. Savage

### 540 Driver Education

#### 1.0 Eligibility for Driver Education

[1.1] 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 1.2]~~ [1.2] 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 1.3]~~ [1.3] 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 1.4]~~ [1.4] 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 1.5]~~ [1.5] 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

[2.1] 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 2.2]~~ [2.2] 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 2.3]~~ [2.3] 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 2.4]~~ [2.4] Driving simulation and off the street driving range time shall not be taken from or cause a reduction of classroom instruction time.

~~[2.4 2.5]~~ [2.5] 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 2.0]~~. This includes individually or in any combination.

#### 3.0 Curriculum

[3.1] 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**

**[4.1]** 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 **[of a]** credit for driver education may be included as part of the elective credits counted toward graduation.

~~**[4.4 4.2]**~~ 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**

**[5.1]** 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 the 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)**~~

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**PROFESSIONAL STANDARDS BOARD**

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

14 **DE Admin. Code** 1501

**REGULATORY IMPLEMENTING ORDER****1501 Knowledge, Skills, and Responsibility Based Salary Supplements for Educators****I. Summary of the Evidence and Information Submitted**

The Professional Standards Board, acting in cooperation and consultation with the Department of Education, seeks the consent of the State Board of Education to amend 14 **DE Admin. Code** 1501. It is necessary to amend this regulation in order to clarify criteria surrounding cluster expiration dates, replication, reauthorization and payment of salary supplements.

Notice of the proposed amendment of the regulation was published in the *News Journal* and the *Delaware State News* on January 29, 2007 in the form hereto attached as Exhibit "A". The notice invited written comments. No comments were received.

**II. Findings of Facts**

The Professional Standards Board and the State Board of Education find that it is appropriate to amend this regulation to comply with changes in statute.

## III. Decision to Adopt the Regulation

For the foregoing reasons, the Professional Standards Board and the State Board of Education conclude that it is appropriate to amend the regulation. Therefore, pursuant to 14 **Del.C.** §1205(b), the regulation attached hereto as Exhibit "B" is hereby amended. Pursuant to the provision of 14 **Del.C.** §122(e), the regulation hereby amended shall be in effect for a period of five years from the effective date of this order as set forth in Section V. below.

## IV. Text and Citation

The text of the regulation amended shall be in the form attached hereto as Exhibit "B", and said regulation shall be cited as 14 **DE Admin. Code** 1501 of the *Administrative Code of Regulations* of the Department of Education.

## V. Effective Date of Order

The effective date of this Order shall be ten (10) days from the date this Order is published in the *Delaware Register of Regulations*.

## APPROVED BY THE PROFESSIONAL STANDARDS BOARD THE 1<sup>ST</sup> DAY OF MARCH, 2007

Harold Roberts, Chair  
Sandra Falatek  
Karen Gordon  
Barbara Grogg  
Lori Hudson  
Mary Mirabeau  
Karen Schilling Ross  
Kathleen Thomas

Edward Czerwinski  
Mary Furbush  
Richard Gregg  
Leslie Holden  
Carla Lawson  
Gretchen Pikus  
Michael Thomas  
Carol Vukelich

## FOR IMPLEMENTATION BY THE DEPARTMENT OF EDUCATION:

Valerie A. Woodruff, Secretary of Education

## IT IS SO ORDERED THIS 15<sup>TH</sup> DAY OF MARCH, 2007

## STATE BOARD OF EDUCATION

Jean W. Allen, President  
Mary B. Graham, Esquire  
Barbara Rutt  
Dr. Claibourne D. Smith

Richard M. Farmer, Jr., Vice President  
Gregory A. Hastings  
Dennis J. Savage

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

### *(Break in Continuity of Sections)*

### 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 of the appropriation approval by the Controller General and the Budget Director] 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)**

*(Break in Continuity of Sections)*

**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 the appropriation approval by the Controller General and the Budget Director]. 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 appropriation approval by the Controller General and the Budget Director]. 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)~~

*(Break in Continuity of Sections)*

### **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. Educators may receive additional salary supplements for successfully completing other approved clusters, subject to the limitations set forth in Section 11.0. No educator is entitled to payment for the same cluster more than once.]~~

~~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). **[Salary supplements are subject to an annual appropriation.]** 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)**

**\*Please Note: As the rest of the sections were not amended since the proposal in the February 2007 issue, they are not being published here. Please refer to the February 2007 Register, page 1208 (10 DE Reg. 1208) for more information. 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>**

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### **PROFESSIONAL STANDARDS BOARD**

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

### **REGULATORY IMPLEMENTING ORDER**

#### **1516 Standard Certificate**

#### **I. Summary of the Evidence and Information Submitted**

The Professional Standards Board, acting in cooperation and consultation with the Department of Education, seeks the consent of the State Board of Education to amend 14 **DE Admin. Code** 1516. The regulation concerns the requirements for certification of educational personnel, pursuant to 14 **Del.C.** §1220(a). 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.

Notice of the proposed amendment of the regulation was published in the *News Journal* and the *Delaware State News* on January 29, 2007 in the form hereto attached as Exhibit "A". The notice invited written comments. A concern was raised by the State Council for Persons with Disabilities regarding language in Section 6.3. One of the Council's suggestions was incorporated into the amended regulation.

## II. Findings of Facts

The Professional Standards Board and the State Board of Education find that it is appropriate to amend this regulation to comply with changes in statute.

## III. Decision to Adopt the Regulation

For the foregoing reasons, the Professional Standards Board and the State Board of Education conclude that it is appropriate to amend the regulation. Therefore, pursuant to 14 **Del.C.** §1205(b), the regulation attached hereto as Exhibit "B" is hereby amended. Pursuant to the provision of 14 **Del.C.** §122(e), the regulation hereby amended shall be in effect for a period of five years from the effective date of this order as set forth in Section V. below.

## IV. Text and Citation

The text of the regulation amended shall be in the form attached hereto as Exhibit "B", and said regulation shall be cited as 14 **DE Admin. Code** 1516 of the *Administrative Code of Regulations* of the Department of Education.

## V. Effective Date of Order

The effective date of this Order shall be ten (10) days from the date this Order is published in the *Delaware Register of Regulations*.

**APPROVED BY THE PROFESSIONAL STANDARDS BOARD THE 1<sup>ST</sup> DAY OF MARCH, 2007**

Harold Roberts, Chair  
Sandra Falatek  
Karen Gordon  
Barbara Grogg  
Lori Hudson  
Mary Mirabeau  
Karen Schilling Ross  
Kathleen Thomas

Edward Czerwinski  
Mary Furbush  
Richard Gregg  
Leslie Holden  
Carla Lawson  
Gretchen Pikus  
Michael Thomas  
Carol Vukelich

**FOR IMPLEMENTATION BY THE DEPARTMENT OF EDUCATION:**

Valerie A. Woodruff, Secretary of Education

**IT IS SO ORDERED THIS 15<sup>TH</sup> DAY OF MARCH, 2007**

**STATE BOARD OF EDUCATION**

Jean W. Allen, President  
Mary B. Graham, Esquire  
Barbara Rutt  
Dr. Claibourne D. Smith

Richard M. Farmer, Jr., Vice President  
Gregory A. Hastings  
Dennis J. Savage

**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 ~~requested~~ **[appropriate requested]**; 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 achieved]** 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 Met]** 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 Met]** 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., including] 14 DE Admin. Code, [Ch. 15, et. al. 1500, et. seq.]~~), 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 since the proposal in the February 2007 issue, they are not being published here. Please refer to the February 2007 *Register*, page 1213 (10 DE Reg. 1213) for more information. 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)

### ORDER

#### Long Term Care Medicaid

#### NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings 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). 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 February 2007 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by March 2, 2007 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

#### 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.

## SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

The State Council for Persons with Disabilities (SCPD) and Attorneys-at-Law, Thomas Herlihy, III and Laurence I. Levinson offered the following observations and recommendations summarized below. DMMA has considered each comment and responds as follows.

### SCPD

First, in Section 20320.2.2.2, the last sentence should include after "addition", the words and punctuation "effective 4/1/06". See similar caveat in Section 20320.2.2 and DRA Section 6016(e).

**Agency Response:** DMMA agrees and have made this change.

Second, in Section 20320.2.2, last sentence, DMMA may wish to substitute "provided" for "providing".

**Agency Response:** DMMA agrees and have made this change.

Third, in Section 20330.3, second bullet, substitute "of" for "or" after the word "deferral".

**Agency Response:** DMMA agrees and have made this change.

Fourth, Section 20330.3, third paragraph, is structurally flawed. It recites that "DMMA will use the outstanding principal balance in determining resources unless the individual submits within 30 days the following information:" The "following information section is then deleted in its entirety. Council recommends retention of the current Pars. "a" and "b" and retention of the "strike out" language in the second paragraph. For example, an applicant may hold a note for an individual or firm that has filed bankruptcy or have a mortgage on real estate which has been condemned or been destroyed. The applicant should be allowed to demonstrate that the "principal balance" is not an accurate reflection of the true value of the note, mortgage, or other instrument.

**Agency Response:** Although, the comment is accurate, the applicant's opportunity to rebut exists in §20320.2.2.6, *Rebuttal*. No change will be made to the regulation as a result of this comment.

### Mr. Herlihy

20320.2.2 Life Estates

The last sentence of the proposed rule provides that: "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." There is no requirement in the language of the DRA or elsewhere that requires the purchaser of a life estate to "continue(s) to live in the property." The proposed rule goes beyond the federal statute, which is not permitted.

**Agency Response:** The language of the regulation is intended to be synonymous with the federal statute. CMS has given States considerable flexibility to define the parameters in creating regulations. Please, for clarification, see §§20320.2.2.1 and 20320.3. No change will be made to the regulation as a result of this comment.

#### Mr. Levinson

##### 1) Purchase of Promissory Notes, Loans, or Mortgages

The summary of the proposed accurately reflects the language of the DRA. However, the proposed regulation goes beyond the mandate of the DRA and contains provisions that are more restrictive than Federal law and thus cannot be implemented by regulation. The only problem with the additional language at 20330.3 is that it states it will be effective 4/1/2006. That is retroactive and thus unconstitutional. This provision should only apply to promissory notes dated after the effective date of the regulation.

**Agency Response:** The transfer provisions of the DRA are effective April 1, 2006. Implementation is effective upon the Secretary's signature. Once implementation begins, DMMA must apply the new rules to all applications filed on or after the effective date to be fully compliant with federal law.

The problem with the proposed regulation is that eliminates the language of 20330.3 that provided that if the individual furnishes reliable evidence that the note has no market value it will not be counted as a resource. The DRA does not mandate that now all promissory notes are now countable resources. In reality it is the opposite, the DRA now has established guidelines for which type of promissory notes will not be considered a resource. The DRA did not mandate any changes in the law as to what is considered a countable resource. In addition, the CMS letter dated July 27, 2006 nowhere states that promissory notes that meet all the criteria outline by the DRA will not be considered a transfer of assets but may be counted as a resource. Just as in the DRA annuity rule it makes no sense to pass legislation stating what will not be counted as a transfer penalty, but even of all the criteria are met, it will be nevertheless considered a resource. Congress had an opportunity to do just that but did not. The regulation cannot legislate.

**Agency Response:** DMMA has always counted Promissory Notes. This is not a change in whether we count promissory notes as a resource or not, but what makes it a transfer of asset and that determines whether it is subject to a penalty or not.

##### 2) Purchase of Life Estates

The summary of the proposed amendment regarding life estates incorrectly cites the DRA. The summary states as follows:

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 following is the complete and only section of the DRA that deals with the purchase of a life estate.

(J) For purposes of this paragraph with respect to a transfer of assets, the term 'assets' includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase."

The DRA only deals with transfer of assets, not whether the asset is considered an excludable resource.

First, the state proposes to comply with this mandate by amending 20320.2.2 by inserting the above language but by adding the phrase "and continues to live in the property" this language is not contained in the DRA. The summary does not contain this phrase either. This would make it meaningless to have a one year requirement because if someone goes into a nursing home, they will not continue to live in the property and they would not file an application for assistance if they were not in a nursing home except in the limited situation of the home and community based waiver.

**Agency Response:** The “summary” offers a general orientation of the change(s) made. This level of detail is contained in the regulation. The language of the regulation is intended to be synonymous with the federal statute. CMS has given States considerable flexibility to define the parameters in creating regulations. Please, for clarification, see §§20320.2.2.1 and 20320.3. No change will be made to the regulation as a result of this comment.

Second, the proposed regulation seeks to amend 20320.2.2.1 by deleting the language “A life estate in home property may be an excluded resource.” The elimination of that phrase is not mandated by DRA.

Although, the DRA did mandate that purchase of life estates will be considered transfers unless the purchaser lives in the home for at least a year, it is silent on the other life estate situations. That is the retention of a life estate and the transfer of a remainder interest. It is clear that the DRA did not change the law with regard to transfers if remainder interests—they are transfers that may incur a penalty. The DRA did not change the law concerning the *retention* of a life estate as opposed to a purchase of a life estate. In fact the CMS letter dated July 27, 2006 states as follows:

The DRA provision pertaining to life estates does not apply to the retention or reservation of life estates by individuals transferring real property. In such cases, the value of the remainder interest, not the life estate, would be used in determining whether a transfer of assets has occurred and in calculating the period of ineligibility.

**Agency Response:** The reference to *section 20320.3 - Principal Place of Residence Section* satisfies this inquiry.

The present policy has been to exclude life estates in “home property” as a countable resource. The proposed regulation appears to be a change in that policy. The DRA does not mandate such a change. If a change in policy is intended towards retained life estates, the Division does not give any reason for such a change, not does it seem like there should be a change in policy.

**Agency Response:** There has been no change in policy. This is just a clarification to explain the difference between “life estates” and “life time rights”. The DRA does not replace current and existing rules on how states treat life estates.

In short, the proposed 20320.2.2 makes no sense as written. It is impossible to have a situation where an applicant is applying for long term care and be able to “continue to live in the property”. Again, the DRA only says a person has to live there for at least a year, but not “continue to live in the property.” That language seems to have been crafted out of thin air. The proposed regulation is meaningless and makes it unclear what the policy is as to retained life estates as opposed to purchased life estates

**Agency Response:** The DRA makes no distinction between “retained life estates” and “purchased life estates”.

Third, the regulation cannot be made retroactive and needs an effective date that does not conflict with the present regulations.

**Agency Response:** The transfer provisions of the DRA are effective April 1, 2006. Implementation is effective upon the Secretary’s signature. Once implementation begins, DMMA must apply the new rules to all applications filed on or after the effective date to be fully compliant with federal law.

The purpose of regulations is to make clear the policy, not the opposite. It is important to the public that the rules regarding qualification are clear and unambiguous. The Division has a duty to the public to promulgate regulations that are consistent with the law and clearly stated.

**Agency Response:** Although many of the provisions of the DRA were effective upon passage on February 8, 2006, DMMA anticipated that Delaware would be given a reasonable amount of time to implement these changes. Due to the significance of the DRA mandates, DMMA pursued formal rulemaking in advance of implementation. DMMA prepared its draft proposed regulations based on formal guidance from CMS on July 27, 2006, which has been incorporated in the regulations. As part of the public notice/comment process from interested parties, DMMA garners feedback which may result in revisions/modifications in the final order regulation. DMMA appreciates the fact that you are fully engaged in this process. Thank you for your thoughtful input.

## FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the February 2007 *Register of Regulations* should be adopted.

**THEREFORE, IT IS ORDERED**, that the proposed regulation to amend the Title XIX Medicaid State Plan and the Division of Social Services Manual regarding the life estate and promissory note provisions mandated by the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) is adopted and shall be final effective April 10, 2007.

Vincent P. Meconi, Secretary, DHSS, March 15, 2007

**DMMA FINAL ORDER REGULATION #07-19  
REVISIONS:**

*(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 provided] 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.~~

*(Break in Continuity of Sections)*

**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, [effective 4/1/06,] 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.

*(Break in Continuity of Sections)*

**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~~ for 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](http://www.ssa.gov/OACT/STATS/table4c6.html).

**\*Please Note: As the rest of the sections were not amended since the proposal in the February 2007 issue, they are not being published here. Please refer to the February 2007 Register, page 1216 (10 DE Reg. 1216) for more information. The rules and regulations for the Department of Health and Social Services is available at: <http://www.state.de.us/research/AdminCode/title16/index.shtml#TopOfPage>**

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## DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Ch. 5, Section 512 (31 **Del.C.** §512)

### ORDER

#### Long Term Care Medicaid - Annuities

##### Nature of the Proceedings:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings to amend existing rules in the Division of Social Services Manual (DSSM) to comply with the treatment of annuities provisions mandated by the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171). The proposal amends rules used to determine eligibility for medical assistance. 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 November 2006 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by November 30, 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 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 Proposals**

The DRA contains a number of provisions necessitating changes to Delaware rules. This regulatory action incorporates the mandatory provisions as it relates to Disclosure and Treatment of Annuities and State Named as Remainder Beneficiary.

DSSM 20330.4.1 is revised and updated as follows:

*Disclosure and Treatment of Annuities*

Current law provides that the term "trust," for purposes of asset transfers and the look-back period, includes annuities only to the extent that the HHS Secretary defines them as such. CMS guidance (Transmittal Letter 64) asks states to determine the ultimate purpose of an annuity in order to distinguish those that are validly purchased as part of a retirement plan from those that abusively shelter assets.

Section 6012 of the DRA requires individuals, upon Medicaid application for long term care services and redetermination of eligibility, to disclose to the state, a description of any interest the individual or community spouse has in an annuity (or similar financial instrument), and regardless of whether the annuity is irrevocable or is treated as an asset.

*Disclosure and Treatment of Annuities on or after February 8, 2006*

For the purposes of being eligible for long term care services under Medicaid, the applicant or the applicant's spouse must disclose any interest in an annuity (or similar financial instrument). Section 6012 of the DRA:

- Mandates the disclosure and treatment of annuities.
- Mandates that the purchase of an annuity be treated as a transfer of assets for less than fair market value unless the State is named as the remainder beneficiary.
- Mandates that an annuity shall be treated as a transfer of assets for less than fair market value unless the annuity is irrevocable, non-assignable, actuarially sound, and provide for equal payments.

*State Named as the Remainder Beneficiary*

Current law only requires the State be named a remainder beneficiary when the annuitant is the client, not the community spouse.

Section 6012(b) of the DRA changes this to include annuities purchased for or by a person who is the community spouse on or after February 8, 2006.

**Summary of Comments Received With Agency Response and Explanation of Changes**

Attorneys-at-Law, Jerry A. Hyman, Laurence I. Levinson and Thomas Herlihy, III, the Governor's Advisory Council for Exceptional Citizens (GACEC) and, the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. DMMA has considered each comment and responds as follows:

**Mr. Hyman**

With respect to *Annuities*, DMMA's proposal rests on the statutory authority of new Federal law, the Deficit Reduction Act (DRA), enacted on February 8, 2006. On the subject of annuities, the DRA added two new subsections to Federal law at 42 U.S.C. §1396p(c), which is entitled, "Taking into account certain transfers of

assets. It is clear that these provisions pertain only to situations when the purchase of an annuity may constitute a transfer of assets. Nowhere do the provisions of the DRA define the inclusion of an annuity as a resource.

In Delaware, the question of whether annuities are countable as resources has been determined in the case of *Delaware Department of Health and Social Services v. Dean*, 781 A.2d 693 (Del. Supr. 2001), affirming a Superior Court case (C.A. No. 00A-05-006, December 6, 2000) on the basis of and for the reasons set forth" in the Superior Court decision includes language that defines resources in Federal Medicaid law.

The Dean decision makes it clear that, under Delaware law, the purchaser of a standard commercial annuity has no property right which can be counted as a resource. The purchaser has only income. That is the supreme law in Delaware, as set forth by the State Supreme Court; it cannot be overridden by any provision in the State Medicaid Manual.

Therefore, the provisions of proposed §20330.1.1.A, which define an annuity as a resource equivalent to the value of its income stream, cannot apply to a standard commercial annuity (an annuity purchased from a commercial issuer which is irrevocable, non-assignable, and provides for equal payments for the entire term).

Furthermore, a "stream of income" also does not constitute a property right equivalent to a resource. This proposed §20330.1.1.A is in direct conflict with other provisions of the State Manual itself, such as DSSM §20200.9, on Relationship of Income to Resources. The proposed regulation would violate this provision by counting an annuity as both income and resources in the same month.

Similar prohibitions on "double-counting" are also found in §20300.3.2 of the DSSM which define "resources" and §20200.6 which lists specific types of annuities as income, namely Social Security, Railroad Retirement and pensions. Like any commercial annuities, they are "streams of income," countable as such, not as resources.

Therefore, the Medicaid Manual should make clear what the law (and common sense dictates). Standard, commercial annuities, when they are in "pay status" (i.e., are actually making monthly payments to the annuitant) are not resources. Proposed §§20330.4.1.A, B, and B.3 should be stricken, or should at least be written to carve out an exception for such annuities so they are not counted as resources.

To make this point abundantly clear, an existing section of the manual, §20300.3.2, should also be amended. That section includes "annuities and their streams of income," as a resource, another violation of Dean and of the common-sense principle that income cannot be a resource, and vice versa.

**Agency Response:** Section 6012(a)(4) of the DRA states that "Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1)."

### **Mr. Levinson**

The "summary of proposals" is inaccurate and misleading. Although, the proposed regulation does indeed incorporate changes mandated by DRA, the proposed regulation proposes changes that are nowhere found in the DRA or CMS guidelines and violate both established state and federal law. The proposed changes are not mandated by the DRA and are illegal in that the type of change to the law that is proposed must be done through the legislature and not by regulation.

The bulk of §20330.4.1.B more or less tracks the DRA. However, the last sentence appears nowhere in the DRA or in present or federal law (or in any other State's implementation of DRA). Simply put, the DRA does not mandate that an irrevocable annuity is a countable resource. On the other hand established Delaware law holds that certain irrevocable annuities are not countable resources.

The issue of whether an irrevocable, nonassignable, no cash value, actuarially sound annuity was a countable resource was settled in Delaware in *Dean v. Delaware Department of Health and Social Services*, a Delaware Superior Court decision affirmed by the Delaware Supreme Court [enclosed].

With a standard, commercial irrevocable annuity, such as described in the Dean case and outlined in the DRA under the transfer provisions, the buyer does not own the purchasing funds and cannot reclaim them. The property right in the annuity cannot be liquidated and therefore is not considered a resource. It is agreed that under present law that the income derived from the annuity may be considered income.

All annuities are not non countable resources. Any revocable annuity is a resource under state and federal law. Any irrevocable annuity that does not comply with all the DRA requirements concerning transfer of annuities is also a countable resource because it will be considered a transfer of assets.

On July 27, 2006, CMS sent a letter to State Medicaid Directors along with enclosures to offer guidance to the implementation of the DRA. The CMS guidance nowhere states that all revocable or irrevocable annuities are

countable resources. Nowhere does CMS state that the total price of the annuity minus and income received to date will be counted as a resource. The word "considered" does not mean "counted". The plain language of the DRA and the CMS guidelines state that the state may take income or resources derived from an annuity into consideration. This is actually a statement of current federal and state law, there is nothing new here. This is settled law. In other words, the DRA still allows states to count income derived from annuities as income, and annuities where resources may be derived as resources.

**Agency Response:** Based on CMS guidance, "total purchase price" is stricken and "fair market value" is added.

The DRA defines "asset" in relation to annuities. For some reason proposed regulation §20330.4.1.B.4 has omitted the language of the DRA. This is a misleading omission and only shows that the authors of regulation want to pick and choose what part of the DRA they want to incorporate. The DRA says that states have to incorporate all the provisions.

It may be helpful in the proposed regulation to define what types of annuities are countable resources and which are not. An example of a regulation that would comply with all law would be as follows:

An applicant or his/her representative shall disclose to the DMMA any interest in any revocable or irrevocable annuity that the Medicaid applicant or his/her representative has an annuity or similar financial instrument. Failure to report an annuity to DMMA may result in possible civil and criminal charges, and potential recovery of benefits that were incorrectly paid. If it is determined that income or resources may be derived from an annuity, such income or resources shall be considered in determining eligibility, including spousal income and resources, and in the post eligibility calculation, as appropriate. If income may be derived from an annuity it shall be considered income. If resources may be derived from an annuity, the total purchase price of the annuity minus any income received to date for which qualification is sought will be counted as a resource.

The above example follows CMS guidelines and the DRA.

**Agency Response:** The language of the regulation is intended to be synonymous with the federal statute. CMS has given States considerable flexibility to define the parameters in creating regulations. This regulation, as proposed, is consistent with the provisions and intent of the DRA.

Finally, the effective date of the proposed to §20330.4.1.B cannot be applied for all annuities purchased after February 8, 2006. Since the DRA does not mandate annuities to be counted as resources, the date of February 8, 2006 is meaningless. Furthermore, there may be people who relied on existing Delaware law and the Medicaid manual and purchased annuities between the effective date of any proposed new regulations. In order to have an orderly transition without needless litigation, in the interest of due process and fundamental fairness, the effective date that any new regulations shall apply should be the effective date of the proposed regulation. This is a fundamental and democratic and legal principal. This is also in fact what most if not all of the states that have implemented DRA have done. It would be legal and administrative quagmire to do otherwise. The alternative is to litigate an unknown number of fair hearings and/or federal lawsuits.

**Agency Response:** Any annuity purchased after February 8, 2006 is subject to the provisions of the DRA.

The proposed changes stated in §20330.4.1.B.3 are also not mandated by the DRA. The DRA does not state anywhere that annuities are to be counted as a resource. The same arguments above apply to this section. Under state and federal law an annuity of the type described in §20330.4.1.B.4 is not a countable resource so cannot be counted in the resource calculation. A community spouse's income is not countable except in relation to the MMMNA calculation. Nowhere does the DRA mandate that if spousal income derived from an annuity is over the maximum MMMNA it is then somehow magically turned into a resource. The DRA does permit the counting of income or resources derived from an annuity in the MMMNA calculation. Likewise the DRA does permit resources derived from an annuity to be used in the spousal resource calculation. If it were the intent of Congress to include any income derived from an annuity as a resource if over the maximum MMMNA it would have been clearly stated in the legislation. Since it is not stated it cannot be implied. If the state wants to change the law they always have the option of going through the legislature.

**Agency Response:** Based on CMS guidance, the second sentence in §20330.4.1.B.3 is stricken and in

the third sentence "total purchase price" is stricken and "fair market value" is added.

Note: Also submitted for consideration by Mr. Levinson is a recent Pennsylvania Federal Court case that was decided on November 21, 2006, specifically addressing spousal annuities.

Finally, just to illustrate the misunderstanding of the law a section of the summary of the proposed regulations reads as follows:

*State Named as the Remainder Beneficiary*

*Current law only requires the State be named a remainder beneficiary when the annuitant is the client, not the community spouse.*

This is a complete misstatement of current Delaware law. Nowhere in current law or regulation is there a requirement that the state be made the remainder beneficiary when the annuitant is the client. This is illustrative of ignorance, irresponsibility or total disregard of the law when proposing the new regulations.

The purpose of regulations is to interpret state and federal law. The purpose of the Medicaid Manual is to interpret that law in a form that case workers may use in making a determination of eligibility. Regulations cannot change existing law only the legislature can. If DSS [DMMA] wants to be truly intellectually honest with these proposed regulations, they will go back and correct the portions that are not mandated by DRA and violate Delaware law.

It is important that DSS [DMMA] enact clear, lawful regulations on treatment of annuities that will be applied consistently. This will make it clear to Medicaid applicants and the Elder Law bar as to what and what is not allowed. A clear regulation and guidelines will make it possible for decisions regarding annuities to be made on a caseworker level, instead of the current practice of sending all annuity cases to the policy administrator for review which often results in cases pending for more than ninety days and inconsistent results.

Enactment of this proposed regulation in its present form will only result in litigation which is a tremendous waste of time and resources given the most likely outcome of that litigation, especially in light of the fact that a denial of a Medicaid application is now appealable directly to federal court.

**Agency Response:** For the sake of clarity, an important change relating to Medicaid annuities was signed into law on December 20, 2006, as part of the Tax Care and Health Care Act of 2006. It changed the word "annuitant" to "institutionalized individual" in Section 6012(b) of the DRA. As such, §20330.4.1.B.1 is amended by striking "annuitant" and inserting "institutionalized individual".

**Mr. Herlihy**

20330.4.1.A

An annuity should not be considered a resource if all of the income therefrom is contributing to the long term care of the Medicaid recipient or applicant.

**Agency Response:** Section 6012(a)(4) of the DRA states that "Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1)."

20330.4.1.B

Criminal or civil charges are clearly inappropriate absent very clear, detailed and timely notice of the requirement to disclose annuities and the intentional failure to disclose. This should be stated in the new rule.

**Agency Response:** Both the CMS and the Attorney General's Office have reviewed the regulation. No changes will be made to §2030.4.1.B as a result of this comment.

20330.4.1.B.2

The failure to disclose sufficient information about annuities as required by the individual, spouse, representative or issuer limits the authority of the State to deny or terminate coverage of ONLY long term care services under section 1917(e)(1) of the Deficit Reduction Act (signed 2/8/06) "DRA" (sec. 6012(a)). Under existing

Medicaid program authority, the State can deny or terminate eligibility for Medicaid entirely based on the applicant's failure to cooperate. CMS Guidelines 7/27/06, SMDL #06-018, page 3. Thus, under the above authority, the State can not deny or terminate coverages other than for long term care services unless it is the applicant or recipient who fails to cooperate. If the issuer of the annuity refuses to cooperate, then the State only has the authority to deny or terminate coverage of long term care services and no other coverages. The proposed rule goes beyond the above authority.

**Agency Response:** The last two sentences of §2030.4.1.B.2 are stricken.

#### 20330.4.1.B.3

This rule treats annuities where the community spouse is the annuitant as part of the community spouse resource "and/or" income allocation. It can't be both resource and income. There's no DRA provision for determining which it is. The last sentence valuing the annuity is contrary to the valuation guidelines in the above proposed rules. The sentence should be made consistent with the other valuation guidelines.

The DRA says nothing to change pre-DRA law concerning the treatment of an annuity as income or resource. Rather, the DRA only says at Sec 1396(e)(4) that the State may deny eligibility "based on the income or resource derived [emphasis supplied] from an annuity." If the actuarially sound annuitization of an annuity resulted in the annuity being treated under Sec 3258.9 of the CMS' State Medicaid Manual as income rather than a resource, then the same result should occur despite the other changes to the treatment of annuities by the DRA.

**Agency Response:** The second sentence of §2030.4.1.B.3 is stricken.

#### 20330.4.1.B.4

This rule appears to require that the purchase of an annuity shall be treated as a transfer of assets without fair consideration unless the annuity is irrevocable, non-assignable, actuarially sound and provides for equal payments AND the State is named in the first position as remainder beneficiary OR second position after the community spouse or minor or disabled, OR the annuity is a retirement fund annuity. This interpretation is based on 42 USC Sec. 1396(p)(c)(1), subsections (F) and (G).

An interpretation more consistent with the DRA is that under (F) the State be named as beneficiary in the first or second position applies only to annuities that do not meet the requirements of (G). This interpretation is consistent with the requirement of Sec. 1396(p)(c)(1) that the Medicaid "application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such annuity or similar financial instrument by the virtue of the provision of such medical assistance." Paragraph (2) refers only to an annuity under (F). It makes no reference to an annuity under (G). This makes sense, because an annuity under (F) must name the State as a preferred remainder beneficiary in order for the purchase of the annuity not to be treated as the disposal of an asset for less than fair market value. No such requirement applies to an annuity under (G). Hence, the statement required by paragraph (2) of Sec. 1396p(e) is limited to only those annuities under (F).

Why would paragraph (2) of Section 1396p(e) require that the statement "the State becomes a remainder beneficiary under such an annuity" be included on applications or recertifications where there is an annuity under (F) but not under (G)? The only answer is that the State must be a remainder beneficiary unless the annuity satisfies the requirements of (G). An annuity that meets the requirements of (G) is not included within the term "assets." Since such an annuity is not an "asset," its purchase cannot be treated as the disposal of an asset for less than fair market value. Only an annuity that is an asset can be treated as the disposal of an asset for less than fair market value under (F). However, (G) explicitly excludes from the term "assets" the retirement annuities described in (G)(i) and non-retirement annuities that are irrevocable and non-assignable, actuarially sound, and provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payment made.

The DRA requirements do not apply to all annuities purchased by the community spouse. As discussed above, (F)'s requirement that the State be named as beneficiary in the first or second position applies only to annuities that do not meet the requirements of (G). Therefore, annuities purchased by the community spouse also should need only name the State as beneficiary if the requirements of (G) are not met.

Even if the community spouse were required to name the State as remainder beneficiary, (F) only requires that the State be named as remainder beneficiary "for at least the total amount of medical assistance paid on behalf of the annuitant [emphasis added]. Unless the applicant is the annuitant, the assistance paid on behalf of the applicant is not relevant. If the community spouse is not applicant and receives no assistance, the State is entitled

to nothing as remainder beneficiary regardless of the assistance paid on behalf of the applicant.

The proposed rules fail to follow the DRA in the above respects.

I do not claim to be the originator of many of the above positions. Much of the above is the work of a team of lawyers of the National Academy of Elder Law Attorneys reviewing the DRA. They did not review the Delaware rules. I have reviewed their reasoning, found it to validly apply to the proposed rules in issue.

**Agency Response:** Items #2 and #3 are stricken in §20330.4.1.B.4. As such, this section is re-numbered, accordingly.

## SCPD & GACEC

First, SCPD did not find any significant substantive inconsistencies between the proposed DMMA regulation and DRA §6012. There are some ostensible anomalies in the DMMA regulations. For example, an annuity purchased with proceeds from an IRA or Roth IRA may explicitly qualify as a "disregarded" transfer of assets [§20330.4.1.b.4, Par. 6] while an annuity purchased with proceeds from a 401(k) or 403(b) plan would not. However, this is the literal result of DRA §6012(c).

**Agency Response:** DMMA agrees that this is the literal result of DRA §6012(c).

Second, there is an error in §20330.4.1.B.1. The clause "(u)nless there is a community spouse, minor child or disabled child who resides in the applicant's home" should be included in the first sentence. Moreover, the second sentence, which refers to the State being named as a beneficiary in "the correct position", is not very illuminating. Consistent with the DRA §6012(b), and §20330.4.1.B.4, Par. 3 (both of which refer to "remainder beneficiary"), consider the following substitute:

In such a case, the State must be named in a secondary or remainder position after the community spouse, minor child or disabled child who resides in the applicant's home or the purchase of the annuity shall be considered a transfer for less than fair market value.

**Agency Response:** DMMA accepts the substitute. §20330.4.1.B.1. has been revised.

Third, §20330.4.1.B.4 could be improved. At a minimum, a semi-colon should be added at the end of Par. 1.b. of this section. Moreover, the format of the section is somewhat confusing. Purchase of an annuity is not treated as a transfer of assets without fair consideration if Par. 1 is met and either Pars. 2, 3, 4, 5, or 6 are met. Conceptually, it would be clearer to configure the section to require that Par. 1 and 2 (including proposed Pars. 2-6 as subparts) be met. The current format is as follows:

Par 1 and  
Par 2 or  
Par 3 or  
Par 4 or  
Par 5 or  
Par 6

SCPD recommends the following format:

Par 1 and  
Par 2  
    Subpart a or  
    Subpart b or  
    Subpart c or  
    Subpart d or  
    Subpart e or  
    Subpart f.

**Agency Response:** DMMA considered your recommendation and has decided to retain the format as proposed.

**Findings of Fact:**

The Department finds that the proposed changes as set forth in the November 2006 *Register of Regulations* should be adopted.

**THEREFORE, IT IS ORDERED**, that the proposed regulation to amend the Division of Social Services Manual regarding the disclosure and treatment of annuities is adopted and shall be final effective April 10, 2007.

Vincent P. Meconi, Secretary, DHSS, March 15, 2007

**DMMA FINAL ORDER REGULATION #07-16****Revisions:****20330 Countable Resources Computation****20330.1 Vehicles**

Vehicles are defined as automobiles, boats, travel trailers, motorcycles etc. The current market value of a vehicle is the average price that it will sell for (based on year, make, model and condition) on the open market in a certain geographic area. Current market value can be determined by using the NADA book (trade in value) or a written appraisal from a disinterested, knowledgeable source. One vehicle may be excluded under Section 20310.5. Only one vehicle may be excluded for a married couple.

If NO vehicle is excluded per Section 20310.5, up to \$4650 of the CMV of ONE vehicle is excluded. If the CMV exceeds \$4650, the excess counts as a resource, unless the vehicle can be excluded under some other provision (i.e., co-owner refuses to sell). It is unlikely the \$4650 exclusion will be used. This is because most vehicles are used for either a medical problem or for essential daily activities and can be excluded per Section 20310.5.

Any vehicle an individual owns in addition to the vehicle that was totally or partly excluded (up to \$4650), is a resource in the amount of its equity value. The equity value is the CMV minus amount owed on the vehicle. The exclusion is applied in the manner most advantageous to the individual. If one of two vehicles can be excluded as necessary for medical treatment, the exclusion is applied to the vehicle with the greater equity value regardless of which vehicle is used to obtain medical treatment.

**20330.2 Financial Institutions Accounts**

Financial institution accounts which include savings accounts, checking accounts, certificates of deposit, etc., are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can access the funds by looking at how the account is titled.

If an individual is designated as sole owner by the account title, all of the funds are that individual's resource unless legal restrictions preclude the owner from using the funds for his or her support and maintenance. We do not provide an opportunity for the owner of an individually-held account to rebut the presumption of 100% ownership.

If the account is in the name of a Medicaid applicant/recipient and another Medicaid applicant/recipient, assume all account funds belong to each individual in equal shares. If the account is in the name of a Medicaid applicant/recipient and another individual who is not applying for Medicaid or who is not a Medicaid recipient, then assume all of the funds belong to the Medicaid applicant/recipient.

If the applicant or recipient disagrees with the ownership presumption on jointly-held accounts, we give the individual the opportunity to rebut the presumption. Rebuttal is a procedure which permits an individual to furnish evidence and establish that some or all of the funds in a jointly-held account do not belong to him or her. Obtain the individual's statement on a form containing the penalty clause regarding who owns the funds, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent. Inform the individual that he or she must submit the following evidence within 30 days:

- a corroborating statement from the other account holder(s). If the other account holder is incompetent or a minor, have the individual submit a corroborating statement from anyone aware of

the circumstances surrounding establishment of the account; account records showing deposits, withdrawals and interest paid for the months that ownership is an issue; if the individual owns none of the funds, evidence showing that he or she can no longer withdraw funds from the account; if the individual owns only a portion of the funds, evidence showing removal from the account of the individual's funds or removal of the funds owned by the other account holder(s) and redesignation of the account.

Any funds that the evidence establishes were owned by the other account holder(s) are not and were not the individual's resources. The effect of a successful rebuttal is retroactive as well as prospective.

### **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 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.

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.

### **20330.4 Retirement Funds**

Retirement funds are annuities or work-related plans for providing income when employment ends, such as pensions, individual retirement accounts (IRA), disability, Keogh plans and some profit sharing plans.

The value of a retirement fund is the amount of money that an individual can currently withdraw. If there is a penalty for early withdrawal, the fund's value is the amount available after the penalty deduction. Any taxes due are not deductible in determining the fund's value. A retirement fund is not a resource if an individual must terminate employment in order to obtain any payment.

If an individual is eligible for periodic retirement benefits, the individual must apply and accept the periodic benefit. If the individual has a choice between periodic benefits and a lump sum, the individual must choose the periodic benefits.

#### **20330.4.1 Annuities**

An annuity is a financial device between an individual and a commercial company that conveys a right to receive periodic payments for life or a fixed number of months or years.

##### **20330.4.1.A**

###### **A. Treatment of annuities purchased prior to February 8, 2006:**

While the annuity itself may or may not be an available resource, the stream of income generated by the annuity is a countable **[asset income]**. ~~The applicant must demonstrate to DSS DMMA that will determine if there is a market to purchase the annuity stream of income does not exist. If there is a market exists, DSS DMMA will consider the annuity to be an it to be available resource. for the applicant's or spouse's support and maintenance. See 20 CFR 416.1201 (a).~~

~~[To calculate the value of the annuity's stream of income, DSS DMMA will use the amount at which the annuity was originally purchased and subtract all payments received to date. The remainder is the value of the annuity's income stream.]~~ DSS DMMA will require the annuity income stream be sold at Fair Market

Value as a ~~[condition of eligibility resource]~~. See DSSM 20350.1.7 **[Fair Market Value (FMV)]**.

DSS DMMA will not count the value of an annuity purchased by a third party, e.g., the applicant's employer, as a retirement benefit to the applicant. However, DSS DMMA will count the value of the income generated from a third party annuity.

An annuity that is revocable is always a countable resource. Revocable annuities are able to be converted to cash.

Spouses that claim the income allowance is inadequate to meet the needs of the Community Spouse may request additional resources be set aside to bring their income up to the minimum maintenance needs allowance. These requests MUST go through the fair hearing process in order to retain excess resources for their protected income share. See DSSM 20970 and 42 USC 1396r-5(e). In these cases, at the death of the annuity's owner, the beneficiary of the annuity must be the estate of the Medicaid recipient.

8 DE Reg. 1617 (5/01/05)

#### **20330.4.1.B**

##### **B. Treatment of Annuities purchased on or After February 8, 2006:**

~~[As a condition of eligibility, A a]n applicant or his/her representative shall disclose to DMMA any interest in any revocable or irrevocable annuity that the Medicaid applicant or his/her spouse has in an annuity or similar financial instrument [as defined by the Secretary of Health and Human Services]. Failure to report an annuity to DMMA may result in possible civil and criminal charges, and potential recovery of benefits that were incorrectly paid. The [total purchase price fair market value] of the annuity minus any income received to date will be counted as a resource.~~

#### **20330.4.1.B.1**

~~[As a condition of eligibility, the The] State of Delaware must be named as the beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the [annuitant. Unless institutionalized spouse, unless] there is a community spouse, minor child or disabled child who resides in the applicant's home. In such a case, the State must be named as a beneficiary in the correct position or the purchase of the annuity shall be considered a transfer for less than fair market value.~~

#### **20330.4.1.B.2**

~~The State of Delaware shall notify the issuer of the annuity of its interest and beneficiary status. This notice shall require the issuer to notify the State of any changes in the amount of income, principal or beneficiary to the annuity. Any transactions that occur on or after 2/8/06, subject the annuity to Deficit Reduction Act rules, even if the annuity was originally purchased prior to 2/8/06. Transactions may include such things as addition of principal, elective withdrawals, requests to change the beneficiary, and elections to annuitize the contract. [The applicant/recipient may be held liable for the issuer's failure to respond to the agency's request for information. Should the issuer not respond to agency requests in a timely manner, it will be assumed that a transfer of assets has occurred and the applicant/recipient's Medicaid benefits may be denied and or terminated.]~~

#### **20330.4.1.B.3**

~~Annuities purchased where the community spouse is the annuitant will be considered as part of the community spouse resource and /or income allocation. [Any annuities which bring the community spouse's total income allowance over the maximum monthly needs allowance will be counted in the resource calculation. The total purchase price The fair market value] of the annuity shall be the value counted in the spousal resource calculation.~~

#### **20330.4.1.B.4**

~~The purchase of an annuity [by or on behalf of an applicant for medical assistance for Long Term Care services] shall be treated as a transfer of assets without fair consideration unless:~~

1. ~~The annuity is~~
  - a. ~~irrevocable and nonassignable; and~~
  - b. ~~is actuarially sound according to the life expectancy table developed by the Social Security Administration at <http://www.ssa.gov/OACT/STATS/table4c6.html>]; and,]~~
  - c. ~~Provides for payments in equal amounts during the term of the annuity with no~~

deferral or balloon payments; and

~~[2. The State of Delaware, Department of Health and Social Services, Division of Medicaid and Medical Assistance, is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual; or~~

~~3. The State of Delaware, Department of Health and Social Services, Division of Medicaid and Medical Assistance, is named as the remainder beneficiary after the community spouse or minor or disabled child as defined in 1917(c)(2)(A)(ii) and who is named in the first position; or]~~

~~[4. 2.] The annuity is an Individual Retirement Annuity (IRA) as described in Section 408(b) of the Internal Revenue Code of 1986; or~~

~~[5. 3.] The annuity is part of a deemed IRA under a qualified employer plan as described in Section 408(q) of the Internal Revenue Code of 1986; or~~

~~[6. 4.] The annuity was purchased with proceeds from:~~

~~a. An IRA account as described in Section 408(a), 408(c), 408(p), 408(k) or 408A of the Revenue Code of 1986.~~

**\*Please Note: As the rest of the sections were not amended since the proposal in the November 2006 issue, they are not being published here. Please refer to the November 2006 *Register*, page 795 (10 DE Reg. 795) for more information. The rules and regulations for the Department of Health and Social Services is available at: <http://www.state.de.us/research/AdminCode/title16/index.shtml#TopOfPage>**

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## DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

### ORDER

#### DSSM 20330.7 - U.S. Savings Bonds

##### Nature of the Proceedings:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend existing rule in the Division of Social Services Manual (DSSM) regarding the Long Term Care Program related to U.S. Savings Bonds. 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 February 2007 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by March 2, 2007 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

##### Summary of Proposed Amendment

###### *DSSM 20330.7 - U.S. Savings Bonds:*

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 a 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.

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**Summary of Comments Received With Agency Response and Explanation of Changes**

The State Council for Persons with Disabilities (SCPD) offered the following summarized comments. DMMA has considered each comment and responds as follows:

First, for your information, the Summary of the Proposed Change contains many errors. See references to "clarifying", "submitter", "available", and "ubless".

**Agency Response:** DMMA strives for accuracy in its regulations and finds these continued publication errors troublesome. We will continue to work with the publisher to eradicate these spelling errors.

Second, the text of the regulations may not achieve the intent as reflected in the Summary. The Summary characterizes Savings Bonds as an available resource upon purchase unless a waiver of the retention period is requested and denied. The text retains the provision that the "(bonds) are not resources during the retention period." This is ostensibly contradicted later with the addition of "(s)ince bonds are redeemable due to a hardship, the redemption value is treated as an available resource."

**Agency Response:** To increase clarity, the fifth sentence is stricken.

Third, a number of state Medicaid agencies have been adjusting their treatment of U.S. Savings Bonds. The attached Vermont materials compile both objections to treating Savings Bonds as resources upon purchase (including inconsistency with SSA POMS) and Vermont's agreement that the Bond should not be counted as a resource while the waiver request is pending. The Delaware regulation is unclear in this respect.

**Agency Response:** The approach suggested by the SCPD is acknowledged. However, the proposed regulation comports with the CMS guidance letter. No change to the rule language will be made based on the comment.

Fourth, a number of states also include a "grandfather" provision for existing Savings Bonds. For example, Vermont adopted its regulation effective December 1, 2004 with the following exclusion.

Savings bonds purchased before June 15, 2004 that have their minimum retention period expire after that date continue to be an excluded resource if they are not redeemed, exchanged, surrendered, reissued or otherwise become available.

In summary, SCPD would prefer: 1) abandonment of this initiative based on the SSA POMS approach (Savings Bonds are not resources during retention period); but 2) if adopted, there needs to be consistency among the standards and inclusion of a "grandfather" provision akin to the Vermont standard.

**Agency Response:** The regulation conforms to the CMS guidance letter. DMMA will not pursue a "grandfather" provision.

#### Findings of Fact:

The Department finds that the proposed changes as set forth in the February 2007 *Register of Regulations* should be adopted.

**THEREFORE, IT IS ORDERED**, that the proposed regulation to amend the policies for the Long Term Care Program related to U. S. Savings Bonds is adopted and shall be final effective April 10, 2007.

Vincent P. Meconi, Secretary, DHSS, March 15, 2007

#### DMMA FINAL ORDER REGULATION #07-18

#### REVISIONS:

#### 20330.7U.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](http://www.publicdebt.treas.gov)

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## DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

### ORDER

#### Long Term Care Medicaid

#### NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings to amend the Title XIX Medicaid State Plan and 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). 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 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 Proposals**

The DRA contains a number of provisions necessitating changes to Delaware rules. This regulatory action incorporates the mandatory provisions as it relates to: 1) *Lengthening the Look-Back Period*; 2) *Change in the Look-Back Penalty Start Date*; and, 3) *Availability of Hardship Waivers*.

Revised and clarified policy and the fiscal impact for both changes are summarized as follows:

1) *Lengthening the Look-Back Period*

Current law requires states to review the assets of Medicaid applicants for a period of thirty-six months prior to application or sixty months if a trust is involved. This period is known as the "look back period", the period of time within which Medicaid reviews financial transactions of the applicant to determine whether any of those actions would result in Medicaid transfer of assets penalty. Applicants are prohibited from transferring resources during the look back period for less than fair market value.

Section 6011(a) of the DRA lengthens the look-back date to five years, or 60 months, for all income and assets disposed of by an individual.

The look back periods of 36 months for income and assets and 60 months for certain trusts would apply for income and assets disposed of prior to the enactment date.

The proposed amendment provides that for any transfer of assets made on or after the date of enactment of the DRA (February 8, 2006), the look-back period is 60 months.

2) *Change in Look-Back Penalty Start Date*

Under current law, the penalty period starts from the date of the transfer. Using the date of the transfer as the start date provides an opportunity for applicants to preserve assets because some or all of the penalty period may occur while the applicant was not paying privately for long term care.

Section 6011(b) of the DRA changes the start date of the ineligibility period for all transfers made on or after the date of enactment to the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level of care based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any period of ineligibility as a result of an asset transfer policy.

For transfers of assets made on or after the date February 8, 2006, the beginning date of penalty is based on the later of the (1) date of transfer or (2) the eligibility date for Long Term Care services. For transfers before February 8, 2006, the beginning date of penalty is the month that the transfer occurred.

3) *Availability of Hardship Waivers*

To protect beneficiaries from unintended consequences of the asset transfer penalties, current law requires states to establish procedures for not imposing penalties on persons who can show that a penalty would impose an undue hardship.

Section 6011(d) of the DRA adds criteria for the application of the hardship waiver provisions. This section also includes notice requirements as to the possibility for a hardship waiver and the availability of a process by which an applicant for a hardship waiver may appeal an adverse determination of an application. Section 6011(e) also allows the facility in which the institutionalized individual resides to file an application on behalf of the individual.

For transfers made on or after February 8, 2006, the waiver process must provide for notice to recipients that an undue hardship exception exists; a timely process for determining whether an undue hardship waiver will be granted; and a process under which an adverse determination can be appealed. In addition, long-term care providers may file an undue hardship waiver on behalf of the individual with the consent of the individual or the personal representative of the individual.

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The provisions of these amendments are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

## SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

The State Council for Persons with Disabilities (SCPD), the Delaware Health Care Facilities Association (DHCFA) and, Attorneys-at-Law, Thomas Herlihy, III and Laurence I. Levinson offered the following observations and recommendations summarized below. DMMA has considered each comment and responds as follows:

### SCPD

First, Section 20350.3.1 requires that applicants subject to imposition of a period of ineligibility will be provided notice of their right to request an undue hardship waiver. This provision could be improved by adding the following sentence: "The notice shall include the procedure for requesting a waiver, general timetable for processing the request, and appeal rights." Although Section 6011 is not detailed in this context, a meaningful notice should include the above information.

**Agency Response:** An appropriate applicant/recipient notice is in development. DMMA will consider your recommendation.

Section, Section 6011 authorizes states to make "bed hold" payments to a nursing facility to hold a bed up to 30 days for a Medicaid applicant seeking an undue hardship exception. This is an important feature in the DRA since Medicaid "beds" are very limited in number in Delaware and nursing homes can discharge for lack of payment. Unfortunately, consistent with the lack of a "check-off" on the bottom of p. 960, Delaware is not adopting this option. This is not a consumer-oriented omission.

In summary, SCPD recommends addition of the above sentence to Section 20350.3.1 and adoption of the "bed-hold" option.

**Agency Response:** DMMA acknowledges the comment. However, Delaware is not pursuing this bed-hold option and has made no change to the rule language based on the comment.

### DHCFA

#### *Availability of Hardship Waivers*

While the language "In addition, long-term care providers may file an undue hardship waiver on behalf of the individual with the consent of the individual or the personal representative of the individual., etc." is appreciated, it does not assure providers of long term care services sufficient and/or appropriate safeguards and/or assurances that they will be paid for services rendered while the State determines whether a Hardship Waiver will be granted or not.

**Agency Response:** DMMA is developing timeliness procedures for hardship waiver requests.

Furthermore, specific language should be included in the proposed regulations and/or statutory changes need to be made to current applicable laws to permit long term care providers to discharge residents for cause promptly when a Medicaid Application is denied for not meeting the "new asset transfer standards" and/or that do not meet the hardship waiver standards that DMMA will promulgate in Delaware to comply with the DRA. The State Plan must somehow supersede the authority of the DLTCRP with regard to discharge if an Application for Medicaid is denied for not meeting the new financial tests established by DMMA applicable to the DRA or assure payment to providers.

If this issue is not resolved appropriately, this will mean that facilities will not admit individuals from hospitals to LTC facilities potentially costing the State more money and more importantly potentially causing a Public Health crisis by further reducing the number of hospital beds available.

**Agency Response:** These issues are beyond the scope of this rulemaking. However, the nursing facility resident may appeal the agency's undue hardship decision and denial of payment of long-term care services. The nursing facility resident's request for consideration of undue hardship does not limit his or her right to request a fair hearing.

*Time of Application Issues*

DHCFA has learned of an alleged current practice used by DMMA dealing with the date used on Medicaid Applications which is troubling. DHCFA has learned that providers are being told to not date Medicaid applications until the day of the actual interview with DMMA. We have heard that it may take 30-60 days for an interview to be granted after an application is completed and an appointment is requested by the family and or provider on behalf of the family. It is our opinion that the application should be dated the day it is completed and submitted to Medicaid with a request for an interview and not the date the interview is granted. The clock for payment to the provider should start at the time of submission.

DHCFA believes that this alleged practice is against CMS guidelines to the States and in violation of the State Plan. For this reason, we object to the proposed language and respectfully request clarification of current practices by DMMA as they relate to the dating of applications and the time it takes to obtain an interview to ascertain eligibility.

**Agency Response:** See DSSM 14100.1, Application Filing Date and DSSM 14100.2, Protected Filing Date.

**Mr. Herlihy***20350.2.1 Look-Back Date*

It would be administratively inconvenient and would create an unnecessary burden on Medicaid caseworkers if Delaware imposed a five-year look-back period prior to February 2011. Delaware should, therefore, clarify that the increased look-back period will in effect be "phased in" over two year period (i.e. beginning in March 2009, 37 months of statements may be requested, in April 2009, 38 months of statements may be requested, etc.) and that it will take until February 8, 2011, before a full 5 years of statements relating to transfers made on or after February 8, 2006, may be requested.

**Agency Response:** The transfer provisions of the DRA are effective February 8, 2006. Implementation is effective upon the Secretary's signature. Once implementation begins, DMMA must apply the new rules to all applications filed on or after the effective date to be fully compliant with federal law.

*20350.2.2 Look-Back Period*

The last sentence fails to make clear that even with applications after February 8, 2006, the 36 month look-back period will apply to non-trust financial data for transfers prior to February 8, 2006, as is stated in the summary of the proposed amendments on page 2.

**Agency Response:** The last sentence is revised to read as follows: "Any transfers that occur on or after 2/8/06 will be subject to a 60 month look-back period."

*20350.3.1 Penalty Period for Assets Transferred on or after 2/8/06*

The legislative history of the DRA does not support the conclusion that an individual must be residing in a nursing home in order for a penalty period to begin. The regulation should clarify that an individual need NOT reside in a nursing home in order for a penalty period to begin or continue to run. None of the language of the DRA, the House Bill, or the Conference Agreement could be interpreted to require that an individual would need to be residing in a nursing home in order to start or continue the running of a penalty period. The Conference Report specifies that one prong of the test for determining whether the penalty period commences is that the individual "...would otherwise be receiving institutional level care..." Institutional level care is defined in 42 U.S.C. section 1396p(c)(1)(C) as nursing facility services, a level of care of any institution equivalent to that of using facility services, or home and community-based services furnished under a waiver granted under subsection (c) or (d) of 1396n. While nursing home residence could satisfy this prong of the test for determining whether a penalty period would commence under the DRA; so too could residence in a facility where nursing home level of services were being provided or certain waived home and community-based services provided in the community.

The proposed rules fail to follow the DRA in the above respects.

I do not claim to be the originator of many of the above positions. Much of the above is the work of a team of lawyers of the National Academy of Elder Law Attorneys reviewing the DRA. They did not review the Delaware rules. I have reviewed their reasoning, found it to validly apply to the proposed rules in issue.

**Agency Response:** Based on CMS guidance, in order to receive an institutional level of care, clients need to be institutionalized. No change is made to the rule as a result of this comment.

## Mr. Levinson

This proposed regulation does not track what the DRA requires. The DRA states as follows:

The look back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) of this section or in the case of any disposal of assets made on or after the date of enactment of the Deficit Reduction Act of 2005 (60 months).

The difference is that under the DRA that date of the *transfer* is the critical date for determination of a 36 month or 60 month look back. The DRA does not calculate the look back period based on the date of the application. This means that under the DRA the 60 month look back applies to any transfer to or from a trust, and any transfer of assets made after February 8, 2006. If the proposed regulation is enacted as proposed it will violate the law because it would apply a 60 look back to any application made after February 8, 2006 when the 60 month look back should only be applied to any transfer made after February 8, 2006. The date of the application is immaterial under the DRA.

Actually, this is what was done when the present regulation was modified previously to accommodate the longer look back period. It should be done the same way it was before. It is exactly the same situation but with a different time period. The 60 month look back will also be phased in and not fully effective until 2007.

**Agency Response:** The words "*applications received*" has been stricken and replaced with "*transfers that occur*" in DSSM 20350.2.2.

The other problem is that as of this time the DSSM states that the look back period is 36 [months] except for transfers made to of [sic] from a trust in which the look back is 60 months. The proposed regulation proposes to use February 8, 2006 as the cut off date. Although, February 8, 2006 is fact the enactment date of the DRA, it was up to each state to modify their regulations to comply. It would be an unconstitutional denial of due process to make the new regulations retroactive to transfers after February 8, 2006 since that was not the law in Delaware at that time. Delaware should do what other states have done and make the effective date the date of the finalization of the regulation, or pick a date in the short future, i.e., March 1, 2007. This approach will not penalize people who made legal transfer under Delaware law as it was at the time of the transfer and will avoid needless litigation.

**Agency Response:** The transfer provisions of the DRA are effective February 8, 2006. Implementation is effective upon the Secretary's signature. Once implementation begins, DMMA must apply the new rules to all applications filed on or after the effective date to be fully compliant with federal law.

In addition to the above, DMMA made grammatical changes to DSSM 20350.2.2 and 20350.3.1 as indicated by **[bracketed bold type]**.

## 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 Title XIX Medicaid State Plan and the Division of Social Services Manual regarding the transfer of assets provisions mandated by the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) is adopted and shall be final effective April 10, 2007.

Vincent P. Meconi, Secretary, DHSS, March 15, 2007

\* Please note that no changes, except as noted below in DMMA Final Order Regulation #07- 15b, were made to the regulation as originally proposed and published in the December 2006 issue of the *Register* at page 955 (10 DE Reg. 955). Therefore, the final regulation is not being republished in its entirety. Please refer to the December 2006 issue of the *Register* or contact the Division of Medicaid and Medical Assistance for more information.

A complete set of the rules and regulations for the Division of Social Services are available at: <http://www.state.de.us/research/AdminCode/title16/index.shtml#TopOfPage>

*(Break in Continuity of Sections)*

**DMMA FINAL ORDER REGULATION #07-15b  
REVISIONS:**

*(Break in Continuity of Sections)*

**20350.2.2 Look-Back Period**

The look-back period is the period that begins with the look-back date and ends with the baseline date. ~~This can be 36 or 60 months, depending on what kind of trust was involved. The look-back period~~ It is the period of time prior to the baseline date (see above) during which a previous transfer of assets for less than fair market value can be penalized. It is important to remember that transfers which occur after the baseline date are also subject to penalty if they are made for less than fair market value.

~~The 36 month look-back period does not become fully effective until August 11, 1996. Prior to that date, a 36 month look-back period would actually begin at some time before the date transfers are covered by these new rules. Since the 36 month look-back period is effective for transfers made on or after August 11, 1993, any transfers made before that date are treated under the rules in effect prior to OBRA 93. Thus, the look-back period is phased in over the 36 month period ending August 11, 1996. Effective 2/8/06, the date of the [Deficit Reduction Act of 2005 (DRA)] enactment, the look-back period was extended from 36 months to 60 months. Any [applications received transfers that occur] on or after 2/8/06 will be subject to a 60 month look-back period.~~

*(Break in Continuity of Sections)*

**20350.3.1 Penalty Period for assets transferred on or after 2/8/06**

Section 6011(b) for the Deficit Reduction Act amends section 1917(c)(1)(D) of the Act to change the start date of the penalty period, which is the period during which an individual is ineligible for Medicaid payment for long term care services because of a transfer of assets for less than fair market value.

The ineligibility period will begin with the LATER of:

- The month during which assets have been transferred for less than fair market value; or
- The date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level of care services (based on an approved application for such services) that, were it not for the imposition of the penalty period, would be covered by Medicaid.

The penalty period cannot begin until the expiration of any existing period of ineligibility. The penalty period will continue to run for the number of days determined by dividing the total value of assets transferred within the look-back period by the State's average daily cost to a private patient of a nursing facility services in the State. Once the penalty period [in is] imposed, it will not be interrupted, but will continue to run even if the individual stops receiving institutional level of care.

For non-institutionalized individuals, the penalty date will not begin until the individual is receiving an institutional level of care.

Upon imposition of a period of ineligibility for long-term care level services because of an asset transfer, applicants/recipients will be notified of the right to request an undue hardship waiver. In addition, long-term care providers may file an undue hardship waiver on behalf of the individual with the consent of the individual or the personal representative of the individual. See DSSM 20400.1.12.1.

~~For example: An individual transferred an asset in May 1993, for which a penalty of 12 months was imposed. The individual transfers another asset in October 1993, to which another 12 month penalty applies. Because the second transfer took place within the first 12 month penalty period, the second penalty period cannot begin until the first period expires, on April 30, 1994. The first penalty period would run from May 1, 1993 through April 30, 1994. The second penalty period would run from May 1, 1994, through April 30, 1995.~~

**\*Please Note: As the rest of the sections were not amended since the proposal in the December 2006 issue, they are not being published here. Please refer to the December 2006 Register, page 955 (10 DE Reg. 955) for more information. The rules and regulations for the Department of Health and Social Services are available at: <http://www.state.de.us/research/AdminCode/title16/index.shtml#TopOfPage>**

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## DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

### 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 February 2007 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by March 2, 2007 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

#### 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 & 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.

### SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The State Council for Persons with Disabilities (SCPD) offered the following comment summarized below.

In April 2006, DMMA adopted regulations adding illustrations to institutionalized spouse standards. Although comments were not solicited, the SCPD objected to characterizing any spouse receiving HCBS as an "institutionalized spouse" which would remove spousal impoverishment protections. CMS then influenced DMMA to agree to delete the illustrations. DMMA then issued new regulations omitting the illustrations. However, the text

still eliminated spousal impoverishment protections if a community spouse were receiving HCBS. CMS then confirmed that it had advised DMMA of its concurrence with the Council's interpretation. DMMA has now published a conforming proposed regulation.

SCPD endorses the final regulation since it now allows non-institutionalized spouse participation in an HCBS waiver to benefit from spousal impoverishment protections.

**Agency Response:** DMMA thanks the Council for endorsing this proposed regulation.

#### FINDINGS OF FACT

The Department finds that the proposed changes as set forth in the February 2007 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual related to the institutionalized spouse is adopted and shall be final effective April 10, 2007.

Vincent P. Meconi, Secretary, DHSS, 3/15/07

\* Please note that no changes were made to the regulation as originally proposed and published in the February 2007 issue of the *Register* at page 1220 (10 DE Reg. 1220). Therefore, the final regulation is not being republished. Please refer to the February 2007 issue of the *Register* or contact the Division of Medicaid and Medical Assistance for more information.

#### 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))  
16 DE Admin. Code 4104

#### ORDER

#### 4104 Conrad State 30/J-1 Visa Waiver Program

#### NATURE OF THE PROCEEDINGS:

The Department of Health and Social Services (DHSS) initiated proceedings to adopt amendments to the Regulations Governing the Conrad State 30/J-1 Visa Waiver Program. The DHSS proceedings to adopt regulations were initiated pursuant to 29 **Delaware Code** Chapter 101 and authority as prescribed by 16 **Delaware Code**, Chapter 1, Subchapter II, Section 122.

On February 1, 2007, The DHSS published in the *Delaware Register of Regulations* (Vol. 10, Issue 8) its notice of proposed regulations, pursuant to 29 **Delaware Code** Section 10115. It requested that written materials and suggestions from the public concerning the proposed regulations be delivered to The DHSS by March 2, 2007, or be presented at a public hearing on February 23, 2007, after which time the DHSS would review information, factual evidence and public comment to the said proposed regulations.

#### FINDINGS OF FACT:

No verbal comments were received during the public hearing and no written comments were received during the official public comment period. The official public comment period was open from February 1, 2007 through March 2, 2007. Verifying documents are attached to the Hearing Officer's record. The regulation has been reviewed and approved by the Delaware Attorney General's office.

The DHSS finds that the proposed regulations, as set forth in the attached copy should be adopted in the best interest of the general public of the State of Delaware.

THEREFORE, IT IS ORDERED, that the State of Delaware proposed Regulations Governing the Conrad

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State 30/J-1 Visa Waiver Program are adopted and shall become effective April 10, 2007, after publication of the final regulation in the Delaware Register of Regulations.

Vincent P. Meconi, Secretary, DHSS, March 15, 2007

\* Please note that no changes were made to the regulation as originally proposed and published in the February 2007 issue of the *Register* at page 1221 (10 DE Reg. 1221). Therefore, the final regulation is not being republished. Please refer to the February 2007 issue of the *Register* or contact the Division of Public Health for more information.

PDF Version (Adobe Acrobat Reader required)

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## 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)

Secretary's Order No.: 2007-A-0010

#### I. Background

A public hearing was held on Wednesday, January 31, 2007 in the DNREC auditorium located at 89 Kings Highway in Dover, Delaware, to receive public comment on proposed amendments to the State of Delaware's Regulation No. 1113, i.e., the Open Burning Regulation. This regulation revision is primarily proposed to: (1) expand the open burning ban window from June 1<sup>st</sup> through August 31<sup>st</sup> in the current regulation, to May 1<sup>st</sup> through September 30<sup>th</sup>; (2) expand the burning ban from only New Castle and Kent counties to statewide; and (3) clarify the prohibitions in the existing regulation and their interaction with other applicable laws and regulations.

On April 15, 2004, the United States Environmental Protection Agency designated Delaware's Sussex County as non-attainment for meeting the 8-hour national ambient air quality standard for ozone. The Department's proposed revisions now intend to include Sussex County in the Ozone Season Open Burning Ban. Due to the expansion of the burning ban statewide, the format of the entire regulation required significant changes since the prohibitions attributable to certain areas would no longer exist. As a result, the approach taken to the amendment by the Department was to delete the existing regulation in its entirety and propose an adoption of a new version at this time. Except for the expansions detailed above, the intent of the proposed changes made are to clarify the implementation of the regulation, based on experience of Departmental staff, and are not intended to be more stringent than the existent regulation.

Numerous members of the public were present at this public hearing on January 31, 2007, including, but certainly not limited to, Michael Valenti, Assistant Forestry Administrator for the Delaware Forest Service, Burt Messick of the Sussex County Farm Bureau, numerous private citizens, and Alan Muller, Executive Director of Green Delaware. Questions and comments from those in attendance at the hearing, along with the Department's responses to the same, were fully addressed by the Department's Response Document dated March 6, 2007, which was expressly incorporated into the Hearing Officer's Report dated March 13, 2007. Proper notice of the hearing was provided as required by law.

#### II. Findings

The Department has carefully considered all relevant public input regarding its proposed regulation, and has provided a reasoned analysis and a sound conclusion with regard to the response given to each such comment, as reflected in the Hearing Officer's Report of March 13, 2007, which is attached and expressly incorporated into this Order. Moreover, the following findings and conclusions are entered at this time:

1. Proper notice of the hearing was provided as required by law.
2. Sussex County, Delaware, has recorded 8-hour ozone standard exceedances since 1997. Moreover, Sussex County has yet to record three (3) successive years without an 8-hour ozone exceedance.
3. The Clean Air Act (CAA), Section 110, requires states with areas that fail to meet the National Ambient Air Quality Standards (NAAQS) to develop a State Implementation Plan (SIP), describing how the state will attain and maintain the NAAQS. SIPs must include a description of control strategies or measures to control pollution. The Ozone SIP submittal is due USEPA in June 2007, and the attainment demonstration deadline is 2010. While the Department respects the opinion of various citizens and/or agencies, it believes the inclusion of Sussex County in the Ozone Season Burning Ban will aide the State of Delaware in attaining compliance with the Ozone National Ambient Air Quality Standard.
4. The Response Document from AQM dated March 6, 2007 provided to the Hearing Officer provides a thorough, accurate and balanced summary of the record developed in this matter, by addressing all of the issues, presenting the evidence, providing a reasoned analysis, and offering a recommended course of action, and is therefore expressly incorporated herein for that purpose.
5. In accordance with the Regulatory Flexibility Act, the Department believes that the clarifications made in response to the public comments received in this matter are lawful, feasible and desirable, and that the revisions as proposed should be applied to all Delaware citizens equally in order to create a sufficient reduction toward Delaware's progress to achieving the NAAQS attainment for ozone and particulate matter.
6. The proposed Regulation No. 1113, in its revised final version, is supported by the record developed in this matter, and should be adopted as the Department's final action and be published as a Notice in the *Delaware Register of Regulations* in the next available issue.
7. The Department has an adequate record for its decision, and no further public hearing is appropriate or necessary.

### III. Order

Based on the record developed, as reviewed in the Hearing Officer's Report dated March 13, 2007, and expressly incorporated herein, it is hereby ordered that the State of Delaware Regulation No. 1113 be promulgated in final form in the customary manner and established rule-making procedure required by law.

### IV. Reasons

The promulgation of Regulation No. 1113, specifically, the inclusion of Sussex County in the Ozone Season Burning Ban, will aide the State of Delaware in attaining compliance with the Ozone National Ambient Air Quality Standard. Additionally, this rulemaking represents careful, deliberate and reasoned action by this agency to address the air quality issues affecting Delaware at this time. In developing this regulation, the Department has balanced the absolute environmental need for the State of Delaware to promulgate regulations concerning this matter with the important interests and wide array of public concerns surrounding the same, in furtherance of the policy and purposes of 7 **Del.C.** Ch. 60.

John A. Hughes, Secretary

~~Regulation No. 13~~  
~~Open Burning~~

02/08/95

~~1.0 Prohibitions—All Counties~~

- ~~1.1 No person shall cause or allow the disposal of refuse by open burning.~~
- ~~1.2 No person shall cause or allow open burning in the conduct of a salvage operation.~~
- ~~1.3 No person shall cause or allow the open burning of fallen leaves.~~

02/08/95

~~2.0 Prohibitions—Specific Counties~~

- ~~2.1 Kent and New Castle Counties:~~

~~2.1.1 No person shall cause or allow open burning from June 1 through August 31.~~

~~2.1.2 The Department may grant permission to conduct open burning between June 1 and August 31 for circumstances that threaten the health, safety or welfare of any person or persons. Such circumstances must pose a more serious threat than the health threat posed by the open burning. Permission will be granted to applicants on a case-by-case basis.~~

~~02/08/95~~

### **3.0 General Restrictions—All Counties**

~~3.1 Open burning, as permitted by this regulation, may be conducted without prior approval of the Department, except as provided in Sections 3.2.3, 3.2.4, and 3.9.~~

~~3.2 No person shall cause or allow open burning except for the purposes of:~~

~~3.2.1 Domestic burning of branches and limbs that have been cut from trees or shrubbery originating on the premises and conducted by individuals domiciled on the premises;~~

~~3.2.2 The clearing of land in agricultural or silvicultural operations to cultivate and/or prepare the soil for the purpose of producing crops or supporting livestock;~~

~~3.2.3 Prescribed burning for conservation practices, wildlife habitat management, or plant, pest, or disease control, provided that:~~

~~3.2.3.1 The applicant documents to the satisfaction of the Department that prescribed burning is the most effective method to achieve this purpose; and~~

~~3.2.3.2 Permission to burn is given by the Department before such burning takes place;~~

~~3.2.4 The burning of wooden buildings solely for fire fighting instruction conducted by authorized fire companies, provided that:~~

~~3.2.4.1 The company documents to the satisfaction of the Department that all refuse has been removed from the building prior to burning; and~~

~~3.2.4.2 Permission to burn is given by the Department before such burning takes place.~~

~~3.3 No person shall conduct any open burning allowed by this regulation without giving prior notice to the Fire Call Board for the county in which the fire will occur.~~

~~3.4 No person shall conduct open burning as permitted by this regulation when, in the judgement of the Department:~~

~~3.4.1 A condition of air stagnation exists;~~

~~3.4.2 Any national ambient air quality standard may be violated; or~~

~~3.4.3 The open burning causes unreasonable interference with a person's health, safety, comfort, or use or enjoyment of his or her real property.~~

~~3.5 Upon notification by the Department, open burning shall be terminated immediately.~~

~~3.6 All fires shall remain under supervision until completely extinguished.~~

~~3.7 Tires, waste oil, or any oil heavier than No. 2 shall not be used as an auxiliary fuel. Only the minimum amount of auxiliary fuel needed to initiate the fire shall be used.~~

~~3.8 Open burning, as permitted by this regulation, may be conducted only between the hours of 8:00 am and 4:00 pm.~~

~~3.9 Burning outside of the hours permitted in Section 3.8 may be conducted, provided that:~~

~~3.9.1 The applicant documents to the satisfaction of the Department that burning outside of the permissible hours will lead to smoke reduction, or a more efficient, complete, or safer burn; and~~

~~3.9.2 Permission to burn during the extended hours is given by the Department before such burning takes place.~~

~~02/08/95~~

### **4.0 Exemptions—All Counties**

~~4.1 The following operations are exempt from Sections 1.0 through 3.0 of this regulation provided that they are not used for the disposal of refuse and are of a minimum size sufficient for their intended purpose:~~

~~4.1.1 Fires used for cooking of food for human consumption, provided that only unpainted/untreated wood, charcoal, propane, or natural gas is burned;~~

~~4.1.2 Fires used for recreational purposes such as campfires, provided that only unpainted/~~

untreated wood is burned;

- 4.1.3 Ceremonial fires, provided that only unpainted/untreated wood is burned;
- 4.1.4 Flares;
- 4.1.5 Backburning to control or suppress wildfires;
- 4.1.6 Fire fighting instruction conducted by the Delaware State Fire School.

### 1113 Open Burning

~~xx/xx/07~~ 04/11/07]

#### 1.0 Purpose.

The purpose of this regulation is to control air emissions by establishing rules for open burning activities.

[  
~~xx/xx/07~~ 04/11/07]

#### 2.0 Applicability.

This regulation applies to all open burning activity in Delaware.

~~xx/xx/07~~ 04/11/07]

#### 3.0 Definitions.

The following words and terms, when used in this regulation, shall have the following meanings:

**"10-Day Notification"** means a notification that shall be made in accordance with 40 CFR Section 61.145.

**"Agricultural operations"** means an activity on land currently used or intended to be used primarily for the purpose of obtaining a profit in money by raising, harvesting and selling crops or by raising and selling livestock or poultry. Agricultural operation also means activities conducted by not-for-profit agricultural research organizations, which activities are necessary to serve that purpose. It does not include the construction and use of structures customarily provided in conjunction with the agricultural operation.

**"Asbestos"** means any or all of the forms of asbestos including Actinolite, Amosite, Anthophyllite, Chrysotile, Crocidolite, or Tremolite.

**"Asbestos containing material"** means asbestos or any material containing asbestos.

**"Ceremonial fires"** means bonfires used for ceremonies sponsored by educational, cultural, or religious institutions.

**"Code Orange Day"** means a day which has been designated by the Department as a "Code Orange" day for expected pollution intensity.

**"Code Red Day"** means a day which has been designated by the Department as a "Code Red" day for expected pollution intensity.

**"Crop Residue"** means any vegetative material remaining after harvesting, including leaves, stalks, roots.]

**"Department"** means the Department of Natural Resources and Environmental Control as defined in Title 29, Delaware Code, Chapter 80, as amended.

**"Friable asbestos material"** means any material that contains more than 1% asbestos by weight and that can be crumbled, pulverized, or reduced to powder, when dry, by hand pressure.

**"Fuel"** means any combustible matter including, but not limited to coal, gas, oil, and refuse.

**"Garbage"** means animal or vegetable waste matter originating in houses, kitchens, restaurants, hotels, produce markets or similar installations.

**"Incineration"** means the process of igniting and burning solid, semi solid, liquid, or gaseous combustible waste to their products of combustion.

**"Industrial waste"** means any waste produced by a manufacturing process.

**"Material"** means any gas, liquid, or solid or any combination thereof.

**"Open burning"** means any outdoor fire or outdoor smoke-producing process from which the products of combustion are emitted directly into the ambient air. This does not include incinerators, boilers, or heaters used in process operations.

**"Person"** means any individual, firm, association, organization, partnership, business trust, corporation, company, contractor, supplier, installer, developer, user or owner or operator, or any Federal, State or Local

governmental agency or public district or any officer or employee thereof.

**["Perimeter field maintenance"** means the open burning and removal of vegetation from the perimeter of a field in crop production or livestock for the specific purpose of keeping the field free and clear of vegetative obstruction that prohibit the agricultural operations.]

**"Prescribed burning"** means open burning of undisturbed vegetation for the specific purpose of conservation practices, wildlife habitat management, or plant, pest or disease control under such conditions that the fire is confined to a predetermined area.

**"Private dwelling"** means a domestic residence housing no more than three (3) families and where no commercial or industrial activity is conducted.

**"Recreational purposes"** means any purpose which, in the judgment of the Department, fulfills a physical or social need, including, but not limited to, camping, ceremonies, and religious rites.

**"Refuse"** means garbage, rubbish, or trade waste.

**"Rubbish"** means waste solids or liquids including but not necessarily limited to, rags, clothes, leather, rubber, carpets, excelsior, paper, ashes, furniture, tin cans, glass, crockery, masonry, tires, or waste oil.

**"Salvage operation"** means any business, trade or industry engaged entirely or partially in salvaging or reclaiming any product or material, including, but not necessarily limited to metal, chemicals, motor vehicles, shipping containers or drums.

**"Silviculture"** means the care and cultivation of forest trees.

**"Solid fuel"** means a fuel which is fired as a solid, such as anthracite or semi anthracite, bituminous or sub bituminous coal, lignite, coke, wood, or any solid by product of a manufacturing process that may be substituted for any of the above specifically mentioned fuels.

**"Solid waste"** means refuse, more than 50 percent of which is municipal type waste consisting of a mixture of paper, wood, yard wastes, food wastes, plastics, leather, rubber, and other combustibles and noncombustible materials such as glass and rock.

**"Standard for Demolition and Renovation"** of the asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as adopted through July 1, 2006.

**"Trade waste"** means any solid, liquid, or gaseous waste material or rubbish resulting from construction, land clearing for construction or development, building operations, or the prosecution of any business, trade, or industry including, but not necessarily limited to, wood, plastic products, cartons, paint, grease, oil and other petroleum products, chemicals or cinders.

**"Waste oil"** means used or spent oil or solvents or other volatile hydrocarbons, including but not limited to crankcase oil.

~~[xx/xx/07 04/11/07]~~

#### **4.0 Prohibitions and Related Provisions**

4.1 No person shall cause or allow open burning of refuse.

4.2 No person shall cause or allow open burning in the conduct of a salvage operation.

4.3 No person shall cause or allow the open burning of fallen leaves.

4.4 No person shall cause or allow open burning otherwise permitted by this regulation when, in the judgment of any Department employee, fire marshal or law enforcement officer:

4.4.1 A condition of air stagnation exists or a Code Red or Code Orange has been issued; or

4.4.2 The open burning impacts a person's health, comfort, use, or enjoyment of his or her real property.

4.5 No person shall conduct any open burning allowed by this regulation without giving prior notice to the Fire Call Board for the county in which the fire will occur.

4.6 No person shall use tires, waste oil, off-specification oil or any oil heavier than No. 2 as an auxiliary fuel for an open burn.

4.7 Any person causing or allowing open burning shall remain present and closely supervise all fire(s) at all times until the fire(s) are completely extinguished.

4.8 No person shall use more than the minimum amount of auxiliary fuel needed to initiate an open burn.

4.9 Upon being instructed to do so by any Department employed enforcement officer, fire marshal, fire officer in charge or law enforcement officer, any person shall immediately cease open burning and shall

immediately extinguish all active open burning on their property or under their control.

4.10 No person shall cause or allow any open burning when a burn ban has been issued by the Delaware State Fire Marshal, even though the activities would have otherwise been permitted by this Regulation.

4.11 This regulation shall not be construed to permit open burning where it is otherwise prohibited.

4.12 No person shall burn for the purpose of land clearing except as permitted in 6.2.2 of this regulation.

~~xx/xx/07~~ 04/11/07]

### **5.0 Season and Time Restrictions**

5.1 No person shall cause or allow any open burning from May 1 through September 30, without prior written approval by the Department. The Department may grant approval to conduct open burning between May 1 and September 30 for circumstances that threaten the health, safety, or welfare of a person or persons. ~~The applicant must demonstrate to the satisfaction of the Department that such circumstances pose a more serious threat than the health threat posed by the open burning. Approval will be granted to applicants on a case-by-case basis.~~

**[5.1.1 The applicant must demonstrate to the satisfaction of the Department that such circumstances pose a more serious threat than the health threat posed by the open burning; or**

**5.1.2 The applicant will consult with the Delaware Department of Agriculture to insure that the proposed open burning activity meets best management practices prior to the Department approving requests for an emergency agricultural/silvicultural open burning activity during the ozone season; and**

**5.1.3 Approval will be granted by the Department to applicants on a case-by-case basis.]**

5.2 No person shall cause or allow open burning, as permitted by this regulation, except between the hours of 8:00 a.m. and 4:00 p.m.

5.3 Burning outside of the hours permitted in 5.2 of this regulation may only be conducted, if the person causing or allowing the fire meets the following criteria:

5.3.1 In order to burn during extended hours, the person causing or allowing the open burn must submit an application to the Department containing documentation sufficient to satisfy the Department that burning outside of the permissible hours will lead to smoke reduction, or a more efficient, complete, or safer burn; and

5.3.2 Approval to burn during extended hours is given by the Department before such burning takes place.

~~xx/xx/07~~ 04/11/07]

### **6.0 Allowable Open Burning**

6.1 Open burning, as permitted by this regulation, may be conducted without prior approval of the Department, except as provided in 5.1, 5.3, 6.2.2, 6.2.3, and 6.2.4 of this regulation.

6.2 Subject to other restrictions in this regulation, open burning may occur for the exclusive purposes of:

6.2.1 Domestic burning of brush, branches, and limbs that have been cut from trees or shrubbery originating on the premises and conducted by individuals domiciled in a private dwelling on the premises, of a size no greater than 27 cubic feet of material, in total, to be burned and where burning is conducted as far as practicable from any adjacent property;

6.2.2 Clearing land in agricultural use and clearing land in silvicultural operations of vegetative material in order to cultivate and/or to prepare the soil for the purpose of producing crops or supporting livestock, provided that:

6.2.2.1 ~~The applicant documents to the satisfaction of the Department that burning in the most effective method to achieve this purpose; and~~ The applicant notifies and provides the Department with information regarding the proposed open burning activity on the Department's approved form; and]

6.2.2.2 ~~Permission Approval~~ to burn is given in writing by the Department before such burning takes place; and

6.2.2.3 The ability to utilize open burning for purposes of clearing land pursuant to this

section shall not apply to land on which residential, industrial or commercial house, dwellings or other structures are constructed with a period of five years after the land clearing by burning takes place. In the even a person is found to have violated the requirements of 6.2.2, in that actions are taken after the burn sot that the burn no longer qualifies as allowable because it falls outside the scope of this exception, the Department, in addition to pursuing an enforcement action for violating this regulation, may recover through its enforcement action an amount equal to the savings that the violator incurred by clearing the land by burning as opposed to using traditional clearing methods.

**[6.2.3 Maintaining the land which includes perimeter field maintenance and crop residue management in continued agricultural operations to produce crops or support livestock, provided that:**

**6.2.3.1 The applicant notifies and provides the Department with information regarding the proposed open burning activity on the Department's approved form; and**

**6.2.3.2 The applicant receives confirmation by the Department of receipt of the complete application before such burning takes place.]**

6.2.~~[3 4]~~ Prescribed burning for conservation practices, wildlife habitat management, or plant, pest, or disease control, provided that:

6.2.~~[3 4]~~.1 The applicant documents to the satisfaction of the Department that prescribed burning is the most effective method to achieve this purpose; and

6.2.~~[3 4]~~.2 **[Permission Approval]** to burn is given by the Department before such burning takes place:

6.2.~~[4 5]~~ The demolition by intentional burning of a structure solely for fire fighting instruction conducted by authorized fire companies, provided that:

6.2.~~[4 5]~~.1The fire company documents to the satisfaction of the Department that all building fixtures such as hot water heaters, boilers and air conditioning units, all materials including household appliances and/or refuse, have been removed from the building prior to burning any portion of the building; and

6.2.~~[4 5]~~.2The fire company documents that any internal asbestos containing materials (including pipe coverings and other insulation) and any external asbestos containing materials (including siding) have been removed from the building prior to burning any portion of the building, and that the 10-day notification of this demolition activity, as required by EPA and the Department has been submitted; and

6.2.~~[4 5]~~.3The fire company documents that it is familiar with the Delaware State Fire Prevention Regulations and it will comply with those regulations and all other applicable health and safety regulations; and

6.2.~~[4 5]~~.4Permission to burn is given by the Department before such burning takes place.

**[6.2.6 Fire fighting instruction that involves burning materials other than structures (e.g. vegetation - wild land fires; fuels used to simulate industrial scale fires) by established fire companies or government agencies (e.g. Delaware Forest Service), provided that:**

**6.2.6.1 The applicant documents to the satisfaction of the Department that burning is the most effective method to achieve this purpose; and**

**6.2.6.2 Approval to burn is given by the Department before such burning takes place.]**

~~[xx/xx/07 04/11/07]~~

**7.0 Exemptions.**

The following operations are exempt from 4.5 of this regulation, and from all provisions of 5.0 and 6.0 of this regulation, provided that the fire is no larger than reasonably necessary to meet the purpose of the activity:

7.1 Fires used for cooking of food for human consumption of a size no greater than 10 cubic feet of material, in total, to be burned, where only the following materials are burned: unpainted and untreated wood, charcoal, propane, or natural gas;

7.2 Recreational fires such as campfires of a size no greater than 27 cubic feet of material, in total, to be burned, where only unpainted and untreated wood is burned;

7.3 Ceremonial fires of a size no greater than 27 cubic feet of material, in total, to be burned, by established groups or tribes, provided that only unpainted and untreated wood is burned;

7.4 Emergency signaling flares;

7.5 Emergency burning or use of any other appropriate technique, by governmental agencies or fire

companies to control or suppress on-going fires:

~~7.6 Fire fighting instruction conducted by the Delaware State Fire School [and by established fire companies on a case by case basis after submitting an application and obtaining specific approval of that application from the Air Quality Management Section of the Department].~~

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**DEPARTMENT OF STATE  
DIVISION OF PROFESSIONAL REGULATION**

**2500 Board of Pharmacy**

Statutory Authority: 24 Delaware Code, Section 2509 (24 **Del.C.** §2509)

**24 DE Admin. Code 2500**

**ORDER**

The Board of Pharmacy ("Board") was established to promote, preserve and protect the public health, safety and welfare by and through the effective control and regulation of the practice of pharmacy and of the registration of drug outlets engaged in the manufacture, production, sale and distribution of drugs, medications and such other materials as may be used in the diagnosis and treatment of injury, and prevention of illness and disease. The Board is authorized by 24 **Del.C.** §2509 to make, adopt, amend, and repeal regulations as necessary to effectuate those objectives.

Pursuant to 24 **Del.C.** §2509, the Board proposed broad amendments to its regulation 8.0 Requirements for Obtaining a Permit to Distribute Drugs on a Wholesale Basis. The proposed amendments to regulation 8.0 were prompted by recent changes in the National Association of Boards of Pharmacy's Model Rules for the Licensure of Wholesale Distributors (Model Rules). The proposed amendments incorporate some, but not all, of the changes to the Model Rules. Minor grammatical, typographic, or stylistic amendments are also included.

Pursuant to 29 **Del.C.** §10115, notice of the proposed amendments and public hearing was published in the *Delaware Register of Regulations*, Volume 10, Issue 6, at page 972 on December 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 January 17, 2007 as originally scheduled. The public hearing was, therefore, rescheduled for March 21, 2007. Notice of the rescheduled hearing was published in the *Delaware Register of Regulations*, Volume 10, Issue 9, at page 1468 on March 1, 2007.

**Summary of the Evidence and Information Submitted**

A representative for the Pharmaceutical Research and Manufacturers of America (PhRMA) appeared and provided comment, substantially as follows: PhRMA welcomes the proposed changes to Regulation 8.0, but they are concerned that the requirements for licensing are not strict enough. PhRMA suggests the Board consider requiring a surety bond for wholesalers and a rigorous criminal background check. PhRMA believes the Board should impose a pedigree requirement. Finally, PhRMA is of the opinion that manufacturers that seek wholesale licensure should not be subject to the new, stricter standards but to the federal minimum standards. A more detailed written position statement was provided to the Board and is on file in the Board office.

**Findings of Fact**

The Board finds that adoption of the proposed amendments is a necessary response to changing wholesale distribution industry practices and is in the best interest of public health, safety, and welfare.

**Decision and Effective Date**

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*.

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## 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 version of the regulations as amended is attached hereto as Exhibit B.

**IT IS SO ORDERED** this 21st day of March, 2007 by the Board of Pharmacy of the State of Delaware.

Don Holst, R.Ph., Chair

Sebastian Hamilton, R.Ph.

Angelo Chiari, R.Ph., Vice Chair

Geoffrey Christ, R.Ph.

Carolyn Calio

David Bonar

Sandra Robinson, R.Ph.

\* 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 972 (10 DE Reg. 972). Therefore, the final regulation is not being republished. Please refer to the December 2006 issue of the *Register* or contact the Board of Pharmacy for more information.

A complete set of the rules and regulations for the Board of Pharmacy is available at: <http://www.state.de.us/research/AdminCode/title24/2500%20Board%20of%20Pharmacy.shtml#TopOfPage>

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## DIVISION OF PROFESSIONAL REGULATION 2500 Board of Pharmacy

Statutory Authority: 24 Delaware Code, Section 2509 (24 **Del.C.** §2509)  
24 **DE Admin. Code** 2500

### ORDER

The Board of Pharmacy ("Board") was established to promote, preserve and protect the public health, safety and welfare by and through the effective control and regulation of the practice of pharmacy and of the registration of drug outlets engaged in the manufacture, production, sale and distribution of drugs, medications and such other materials as may be used in the diagnosis and treatment of injury, and prevention of illness and disease. The Board is authorized by 24 **Del.C.** §2509 to make, adopt, amend, and repeal regulations as necessary to effectuate those objectives.

Pursuant to 24 **Del.C.** §2509, the Board proposed amendments to its regulation 9.0 relating to hospital pharmacies. Specifically, the amendment to 9.0 Hospital Pharmacy removes provisions relating to hospitals served by off-site pharmacies.

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 5, at page 821 on November 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 January 17, 2007 as originally scheduled. The public hearing was, therefore, rescheduled for March 21, 2007. Notice of the rescheduled hearing was published in the *Delaware Register of Regulations*, Volume 10, Issue 9, at page 1468 on March 1, 2007.

### Summary of the Evidence and Information Submitted

No written or verbal comments were received.

### Findings of Fact

The Board finds that adoption of the proposed amendments is in the best interest of the public health,

safety, and welfare. The provisions being removed are either unnecessary or unenforceable.

#### Decision and Effective Date

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.

**IT IS SO ORDERED** this 21st day of March, 2007 by the Board of Pharmacy of the State of Delaware.

Don Holst, R.Ph., Chair	Sebastian Hamilton, R.Ph.
Angelo Chiari, R.Ph., Vice Chair	Geoffrey Christ, R.Ph.
Carolyn Calio	David Bonar
Sandra Robinson, R.Ph.	

\* 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 821 (10 DE Reg. 821). Therefore, the final regulation is not being republished. Please refer to the November 2006 issue of the *Register* or contact the Board of Pharmacy for more information.

A complete set of the rules and regulations for the Board of Pharmacy is available at: <http://www.state.de.us/research/AdminCode/title24/2500%20Board%20of%20Pharmacy.shtml#TopOfPage>

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#### **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

#### **ORDER**

After due notice in the *Register of Regulations* and two Delaware Newspapers, a public hearing was held on March 15, 2007 at a scheduled meeting of the Delaware Board of Professional Land Surveyors to receive comments regarding proposed Regulation 2700. The proposed regulation enables licensees to renew their license online, attest that they have completed the required continuing education and change the period for late renewal of licenses. The proposed regulation was published in the *Register of Regulations*, Vol. 10, Issue 9, February 1, 2007.

#### **Background**

Under Title 24, Chapter 27, one of the qualifications for licensure is that the applicant shall submit evidence that the applicant during each renewal period "shall be required to submit on a board approved form his/her professional development hours obtained in the period defined in Section 10.1 of these rules." Recent improvements in computer services at the Department of State make the online renewal process a viable option. Nonetheless, the current regulations also call for sending in paper records concerning continuing education. The proposed regulation would permit online license renewals, and as part of that improvement would keep the paper filing alternative in place. However, the new regulation would also permit licensees to note in their online filings that they met the continuing education requirement, while also being responsible to maintaining adequate records to confirm their compliance with that requirement during the periodic random audit process. The Board's authority to promulgate rules and regulations implementing or clarifying specific sections of Chapter 27 is set forth in 24 **Del.C.**

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§2702(a)(1). The specific mandate for this rule is set forth in 24 Del.C. §2706(b). The proposed regulation specifically identifies changes related to the practice of professional land surveyors.

## Summary of the Evidence and Information Submitted

No written comments were received. No public comment was received at the March 15, 2007 hearing.

## Findings of Fact with Respect to the Evidence and Information Submitted

The Board carefully reviewed and considered the proposed regulation. It provides for an improved optional method for licensees to meet their reporting and renewal obligations to the Board, while preserving the Board's ability to audit the licensees appropriately for their actual compliance with the continuing education requirements.

In summary, the Board finds that adopting these regulation changes as proposed is in the best interest of the citizens of the State of Delaware and is necessary to protect the health and safety of the general public.

## Decision and Effective Date

The Board hereby adopts the changes to Regulation 2700 to be effective 10 days following publication of this order in the *Register of Regulations*.

## Text and Citation

The text of the revised rule remains as published in Register of Regulations, Vol. 10, Issue 9, March 1, 2007.

SO ORDERED this 15th day of March, 2007.

### BOARD OF PROFESSIONAL LAND SURVEYORS

Michael T. Szymanski, Chairman  
Laurence R. McBride, Vice-Chairman  
Roy B. Kemp III, Secretary  
Elton M. Murray, PLS  
Victor Kennedy, Public Member  
Frank Szczucka, Public Member

## 2700 Board of Professional Land Surveyors

\* Please note that no changes were made to the regulation as originally proposed and published in the February 2007 issue of the *Register* at page 1290 (10 DE Reg. 1290). Therefore, the final regulation is not being republished. Please refer to the February 2007 issue of the *Register* or contact the Board of Professional Land Surveyors for more information.

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](http://www.state.de.us/research/AdminCode/title24/2700%20Board%20of%20Land%20Surveyors.shtml#TopOfPage)

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# GENERAL NOTICES

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## DEPARTMENT OF INSURANCE

### GENERAL NOTICE

Circular Letter 01-2007

**TO: All Insurers Providing Workers Compensation Insurance Coverage In Delaware**

**RE: Exclusion For Sole Proprietorships**

**DATE: March 8, 2007**

It has been brought to the attention of the Delaware General Assembly, Delaware Department of Labor, and Delaware Department of Insurance that some language contained in Senate Bill 1 in the current session, which revised Delaware's workers compensation statute, is unclear with respect to whether sole proprietors, who were previously exempt from the obligation to purchase workers compensation insurance, would now be required to purchase it. As a result of this ambiguity, the Department of Labor has decided not to require any persons who were previously exempt from purchasing workers compensation insurance under Title 19, Section 2308 of the **Delaware Code** to purchase such insurance until such time as the General Assembly re-examines the relevant language in Senate Bill 1 and makes a determination as to how to resolve this issue. This circular letter shall remain in effect pending a resolution which is expected to be in the near future. Each person receiving this notice will receive a subsequent notice when the issue is resolved in the same manner as this announcement.

Matthew Denn, Insurance Commissioner

## DEPARTMENT OF AGRICULTURE NUTRIENT MANAGEMENT COMMISSION NOTICE OF PUBLIC COMMENT PERIOD

### Synopsis:

Nutrient Management Certification Regulation Amendments (Exhibit A): Certification by the Delaware Nutrient Management Program, 2320 S. Dupont Hwy., Dover, DE 19901, is required (3 **Del.C.** §2201 - 2290) for all who apply fertilizer and/or animal manure greater than 10 acres or who manage animals greater than 8,000 pounds of live animal weight. The proposed changes to the certification regulations establish nutrient handling requirements for certain nutrient handlers. The proposed regulation addresses application timing and placement for commercial inorganic fertilizer and organic fertilizer

Comments on the proposed changes will be accepted from April 1, 2007 until April 30, 2007. Any comments should be provided to the Nutrient Management Program office located at 2320 S. Dupont Hwy., Dover, DE 19901, ATTN: William Rohrer.

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## DEPARTMENT OF EDUCATION

The Department of Education will hold its monthly meeting on Thursday, April 15, 2007 at 9:00 a.m. in the Townsend Building, Dover, Delaware.

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## DEPARTMENT OF HEALTH AND SOCIAL SERVICES DIVISION OF MEDICAID AND MEDICAL ASSISTANCE NOTICE OF PUBLIC COMMENT PERIOD

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 Social Services is proposing to amend child care subsidy program policies in the Division of Social Services Manual (DSSM).

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, Program and Development Unit, Division of Social Services, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to (302) 255-4425 (new fax number) by April 30, 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.

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## DEPARTMENT OF INSURANCE NOTICE OF PUBLIC COMMENT PERIOD

### 1301 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

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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](http://www.delawareinsurance.gov) and clicking on the link for "Proposed Regulations."

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., Wednesday, May 2, 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](mailto:michael.rich@state.de.us).

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**DEPARTMENT OF INSURANCE****NOTICE OF PUBLIC COMMENT PERIOD****1307 Group Coordination Benefits (Formerly Regulation 61)**

INSURANCE COMMISSIONER MATTHEW DENN hereby gives notice of a proposed change to **Regulation 1307** relating to **Group Coordination Benefits**. The docket number for this proposed amendment is 383.

The proposed change to the regulation provides that, upon the request of either parent of a dependent child, a carrier shall provide an insurance card to the requesting parent and that if the benefits are not assigned and would be paid to an individual other than the provider, the carrier shall issue the benefits to the parent who sought the treatment for the dependent child. The regulation will also contain non-substantive changes to the numbering of the sections and non-substantive wording changes for better clarity. 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., Wednesday May 2, 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](mailto:michael.rich@state.de.us).

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**DEPARTMENT OF NATURAL RESOURCES AND ENVIRONMENTAL CONTROL****DIVISION OF AIR AND WASTE MANAGEMENT****PUBLIC NOTICE****SAN # 2005-10****Title of the Regulations:**

Regulation No. 1148, "Control Of Stationary Combustion Turbine Electric Generating Unit Emissions"

**Brief Synopsis of the Subject, Substance and Issues:**

DNREC is proposing to develop a new regulation to reduce emissions of nitrogen oxides (NO<sub>x</sub>) from combustion turbine electric generating units, typically known as peaking units.

Delaware's emission inventory data demonstrates that combustion turbines in Delaware are significant NO<sub>x</sub> emitting sources. While some combustion turbines in Delaware generate electricity to meet base-load demands, other combustion turbines generate electricity to meet peak demands. Those periods of peak demand frequently correspond with summer ozone action days. This means that emissions from these units are frequently

at their highest when the health threat from ozone is at its worst. Many of Delaware's peaking units have high emission rates of nitrogen oxides and, therefore, should be evaluated for additional NO<sub>x</sub> emission controls.

The proposed regulation will also reduce NO<sub>x</sub> emissions in the State of Delaware from the subject units during high electric demand days (HEDD). This will meet Delaware's obligation to support the regional HEDD NO<sub>x</sub> reduction initiative for the units subject to this regulation.

**Notice of Public Comment:**

The public comment period for this proposed regulation will extend through at least May 1, 2007. Interested parties may submit comments in writing during this time frame to: Mark A. Prettyman, Air Quality Management Section, 156 S. State St., Dover, DE 19901, and/or statements and testimony may be presented either orally or in writing at the public hearing to be held on Thursday, April 26, 2007, beginning at 6:00 PM in the DNREC auditorium at the Richardson and Robbins Building, 89 Kings Highway, Dover, DE 19901.

**Prepared By:**

Mark A. Prettyman 302-739-9402      3/15/2007  
Name/Phone #                                      Date  
Email address:              mark.prettyman@state.de.us

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**DEPARTMENT OF STATE**  
**DIVISION OF PROFESSIONAL REGULATION**  
**1770 Respiratory Care Practice Advisory Council**  
**PUBLIC NOTICE**

**PLEASE TAKE NOTICE**, pursuant to 29 **Del.C.** Ch. 101 and 24 **Del.C.** §1775(c), the Respiratory Care Practice Advisory Council of the Delaware Board of Medical Practice proposes to revise its rules and regulations. The proposed revision adds two (2) new sections to the rules and regulations to address and regulate the administration of sedation and analgesia by respiratory care practitioners.

A public hearing will be held on the proposed rules and regulations on May 15, 2007 at 2:00 p.m., in the Second Floor Conference Room B of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware 19904. The Council will receive and consider input in writing from any person concerning the proposed rules and regulations. Any written comments should be submitted to the Board office in care of Gayle MacAfee at the above address. The final date to submit written comments shall be at the above scheduled public hearing. Anyone wishing to obtain a copy of the proposed rules and regulations or to make comments at the public hearing should notify Gayle MacAfee at the above address or by calling her at (302) 744-4520.

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**DIVISION OF PROFESSIONAL REGULATION**  
**2000 Board of Occupational Therapy**  
**NOTICE OF RESCHEDULED 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.

The Board has rescheduled the public hearing, which had been scheduled for March 7, 2007. The public hearing will be held on May 2, 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.

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**DIVISION OF PROFESSIONAL REGULATION**  
**2500 Board of Pharmacy**  
**NOTICE OF PUBLIC HEARING**

The Delaware Board of Pharmacy, in accordance with 29 **Del.C.** Chapter 101 and 24 **Del.C.** §2509, proposes amendments to its regulation 2.0. Specifically, the amendments to 2.0 Grounds for Disciplinary Proceeding codify the Board's position that, in good faith and upon reasonable belief, a Pharmacist may withhold a suspected forged prescription for release to law enforcement without fear of disciplinary action by the Board. Minor grammatical, typographic, and stylistic changes are also included.

A public hearing is scheduled for Wednesday, June 20, 2007 at 10:00 a.m. in the second floor Conference Room A of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware 19904. The Board will receive and consider input in writing from any person concerning the proposed regulations. Written comments should be submitted to the Board care of Judy Letterman at the above address. The final date to submit written comments shall be at the public hearing. Anyone wishing to obtain a copy of the proposed regulations or to make comments at the public hearing should contact Judy Letterman at the above address or by calling (302) 744-4504.

The Board will consider promulgating the proposed regulations immediately following the public hearing.

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**DIVISION OF PROFESSIONAL REGULATION**  
**2900 Real Estate Commission**  
**PUBLIC NOTICE**

The Delaware Real Estate Commission, in accordance with 24 **Del.C.** §2905(a)(1), has proposed changes to its Rule 8.0 of its rules and regulations to clarify and simplify the online renewal process. The revisions to Rule 8.0 also eliminate language regarding the assessment of a delinquency fee, because the Division of Professional Regulation determines all fees pursuant to 29 **Del.C.** §8725(c). The Commission also proposed to revise Rule 10.0 of its rules and regulations to implement the changes necessary upon the enactment of House Bill 122, with House Amendment No. 1 and Senate Amendment No. 1 of the 143rd General Assembly. Finally, the Commission proposes to eliminate Regulation 14.0 in its entirety. Regulation 14.0 is no longer necessary because, with the enactment of Senate Bill 370 of the 143rd General Assembly, offerings of out-of-state land sales and promotions are no longer required to be registered with the Delaware Real Estate Commission.

A public hearing will be held on May 10, 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 Real Estate Commission, 861 Silver Lake Blvd., Cannon Building, Suite 203, Dover, Delaware 19904. Persons wishing to submit written comments may forward these to the Commission 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.

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**DIVISION OF PROFESSIONAL REGULATION**  
**3300 Board of Veterinary Medicine**  
**PUBLIC NOTICE**

The Board of Veterinary Medicine pursuant to 24 **Del.C.** §3306 purposes to change Professional Regulation 9.1.2 and 14.1.2. The Board will hold a public hearing on May 8, 2007. Written comments should be sent to Jennifer Myer, Administrative Assistant to the Board of Veterinary Medicine, Division of Professional Regulation, Cannon Building, 861 Silver Lake Boulevard, Suite 203, Dover, DE 19904-2467.

The proposed changes are for the purpose of allowing and facilitating online continuing education attestation.

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**DIVISION OF PROFESSIONAL REGULATION**  
**3700 Board of Examiners of Speech/Language Pathologists, Audiologists and Hearing Aid Dispensers**  
**PUBLIC NOTICE**

The Delaware Board of Examiners of Speech/Language Pathologists, Audiologists and Hearing Aid Dispensers, in accordance with 29 **Del.C.** Chapter 101 and 24 **Del.C.** §3706(a)(1), proposes amendments to its regulation 8.0 relating to the continuing education reporting period and process and the licensure renewal process. Specifically, the proposed amendments to **8.0 Continuing Education For All Licensees** provide for online license renewal, allow for attestation of continuing education (CE) compliance, push the CE completion deadline back to July 31<sup>st</sup> of renewal years, and shift the CE compliance audit from pre-renewal to post-renewal. Minor grammatical, typographic, or stylistic changes are also included.

A public hearing is scheduled for Wednesday, May 9, 2007 at 2:00 p.m. in the second floor Conference Room B of the Cannon Building, 861 Silver Lake Boulevard, Dover, Delaware 19904. The Board will receive and consider input in writing from any person concerning the proposed regulations. Written comments should be submitted to the Board care of Sandra Wagner at the above address. The final date to submit written comments shall be at the public hearing. Anyone wishing to obtain a copy of the proposed regulations or to make comments at the public hearing should contact Sandra Wagner at the above address or by calling (302) 744-4532.

The Board will consider promulgating the proposed regulations immediately following the public hearing.

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**PUBLIC SERVICE COMMISSION**

**Notice of Proposed Rule-making: Amendment of Rules for Granting and Supervising Certificates Of Public Convenience and Necessity for Water Utilities**

**To: All Water Utilities, Consumers, and Other Interested Persons**

Under 26 **Del.C.** §203C, the Public Service Commission ("PSC") holds the authority to grant a Certificate of Public Convenience and Necessity ("CPCN") to authorize an entity to begin water utility operations or to allow an existing water utility to expand its operations or business to a new proposed service territory. This CPCN authority encompasses water utilities subject to the PSC's regulation as well as municipal and other governmental water utilities, districts, or authorities. In 2001, the PSC adopted "Regulations Governing Water Utilities Including the Public Service Commission's Jurisdiction to Grant and Revoke Certificates of Public Convenience and Necessity." See 5 DE Reg. 212 (July 1, 2001). Those regulations set forth the process and criteria for reviewing, granting, or denying requests for CPCNs filed by water utilities.

Pursuant to 26 **Del.C.** §§203C(c) and 209(a), the PSC now proposes to repeal those 2001 rules and replace them with the new "Regulations Governing Certificates of Public Convenience and Necessity for Water Utilities." As outlined in PSC Order No. 7142 (Mar. 20, 2007), the PSC believes the new rules will make improvements in the administration of the CPCN process. The new rules provide for more detailed requirements for notice to affected landowners of the CPCN application and provide specific requirements on the form of notice to

be sent to affected landowners to inform them of their options. The new regulations also set forth new definitions for "Proposed Service Areas" under a requested CPCN, including limiting such territories to contiguous parcels served by the same infrastructure in the case of a CPCN sought under 26 **Del.C.** §203C(e)(1)b. In addition, the new regulations add new provisions that require a water utility to certify that it will serve a new Proposed Service Area within three years and that call for a procedure to explore whether a CPCN should continue if service is not made available within such period.

You can review PSC Order No. 7142 (Mar. 20, 2007) and the proposed new rules in the April, 2007 issue of the Delaware Register of Regulations. You can also review the Order and the new regulations at the PSC's Internet website located at [www.state.de.us/delpsc](http://www.state.de.us/delpsc). Written copies of the Order and proposed regulations can be obtained at the PSC's office at the address located below, for \$0.25 per page.

The PSC now solicits comments, suggestions, compilations of data, briefs, or other written materials about the proposed repeal of the 2001 Water Utility CPCN rules and the adoption of the proposed new Water Utility CPCN rules. If you want to file any such materials, you should submit an original and ten copies of such written documents on or before May 4, 2007. You should file such materials with the PSC at the following address:

Public Service Commission  
861 Silver Lake Boulevard  
Cannon Building  
Suite 100  
Dover, Delaware, 19904  
Attn.: Reg. Dckt. No. 51

If possible, you should accompany such written comments with an electronic version of the submission. Such electronic copy may be filed on a copy-capable CD-Rom disk or send as an attachment to an Internet e-mail addressed to [Karen.nickerson@state.de.us](mailto:Karen.nickerson@state.de.us).

The PSC will also conduct a public hearing on the new proposed regulations on Wednesday, May 16, 2007. That hearing will begin at 10:00 o'clock A.M. and will be held at the PSC's office at the address set forth above. You may also submit comments and materials at such public hearing.

If you are disabled and need assistance or help to participate in the proceedings, please contact the PSC to discuss that assistance. If you want more information or have questions, you can contact the PSC about this matter at (800) 282-8574 (toll-free in Delaware) or (302) 4247 (including Text Telephone). Inquiries can also be sent by Internet e-mail addressed to [andrea.maucher@state.de.us](mailto:andrea.maucher@state.de.us).

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