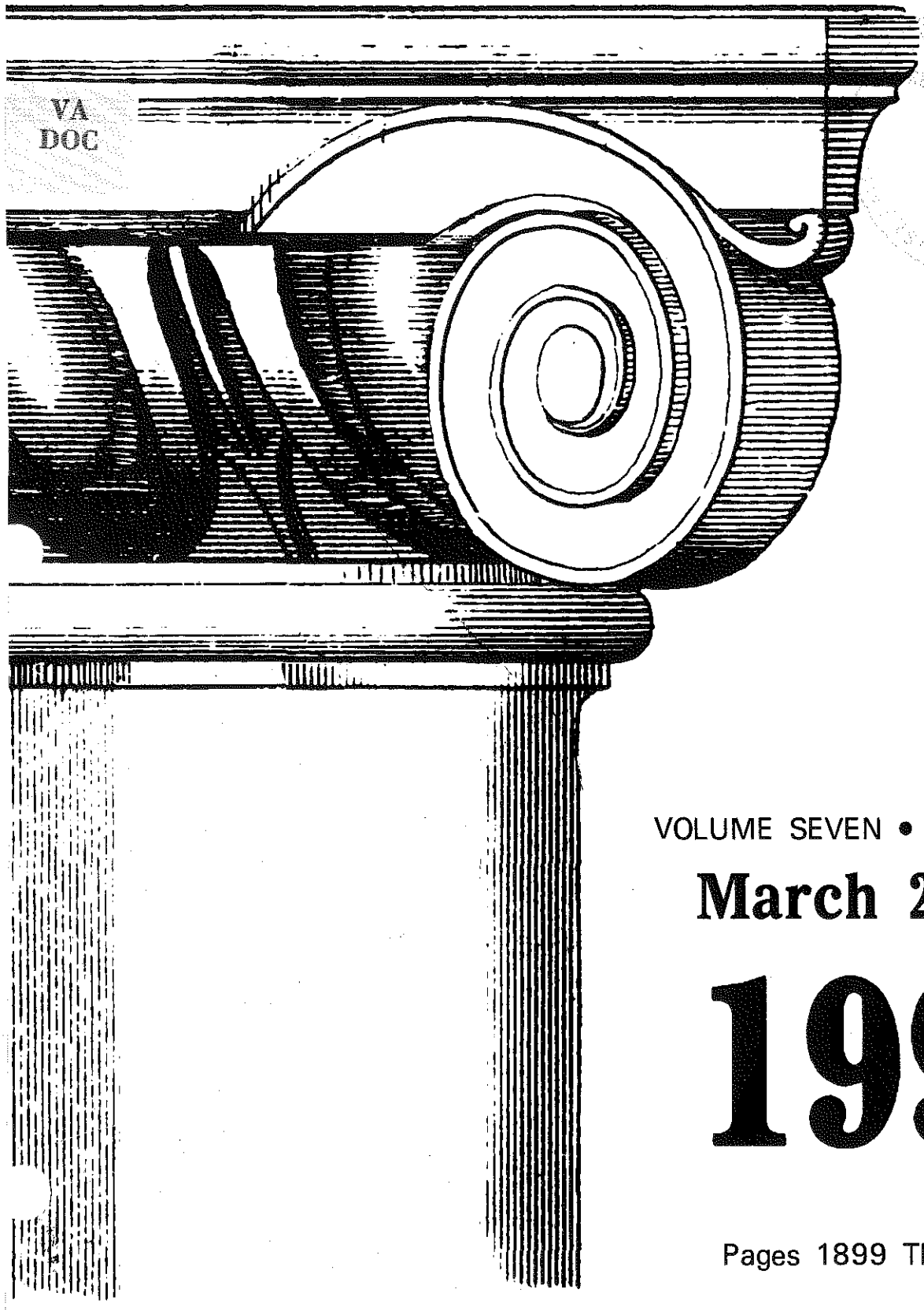
THE VIRGINIA REGISTER

OF REGULATIONS



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VIRGINIA REGISTER

The *Virginia Register* is an official state publication issued every other week throughout the year. Indexes are published quarterly, and the last index of the year is cumulative.

The *Virginia Register* has several functions. The full text of all regulations, both as proposed and as finally adopted or changed by amendment are required by law to be published in the *Virginia Register of Regulations.*

In addition, the *Virginia Register* is a source of other information about state government, including all Emergency Regulations issued by the Governor, and Executive Orders, the Virginia Tax Bulletin issued periodically by the Department of Taxation, and notices of all public hearings and open meetings of state agencies.

ADOPTION, AMENDMENT, AND REPEAL OF REGULATIONS

An agency wishing to adopt, amend, or repeal regulations must first publish in the Virginia Register a notice of proposed action; a basis, purpose, impact and summary statement; a notice giving the public an opportunity to comment on the proposal, and the text of the proposed regulations.

Under the provisions of the Administrative Process Act, the Registrar has the right to publish a summary, rather than the full text, of a regulation which is considered to be too lengthy. In such case, the full text of the regulation will be available for public inspection at the office of the Registrar and at the office of the promulgating agency.

Following publication of the proposal in the *Virginia Register*, sixty days must elapse before the agency may take action on the proposal.

During this time, the Governor and the General Assembly will review the proposed regulations. The Governor will transmit his comments on the regulations to the Registrar and the agency and such comments will be published in the *Virginia Register.*

Upon receipt of the Governor's comment on a proposed regulation, the agency (i) may adopt the proposed regulation, if the Governor has no objection to the regulation; (ii) may modify and adopt the proposed regulation after considering and incorporating the Governor's suggestions, or (iii) may adopt the regulation without changes despite the Governor's recommendations for change.

The appropriate standing committee of each branch of the General Assembly may meet during the promulgation or final adoption process and file an objection with the *Virginia Registrar* and the promulgating agency. The objection will be published in the *Virginia Register.* Within twenty-one days after receipt by the agency of a legislative objection, the agency shall file a response with the Registrar, the objecting legislative Committee, and the Governor

When final action is taken, the promulgating agency must again publish the text of the regulation, as adopted, highlighting and explaining any substantial changes in the final regulation. A thirty-day final adoption period will commence upon publication in the *Virginia Register.*

The Governor will review the final regulation during this time and if he objects, forward his objection to the Registrar and the agency. His objection will be published in the *Virginia Register.* If the Governor finds that changes made to the proposed regulation are substantial, he may suspend the regulatory process for thirty days and require the agency to solicit additional public comment on the substantial changes.

A regulation becomes effective at the conclusion of this thirty-day final adoption period, or at any other later date specified by the promulgating agency, unless (i) a legislative objection has been filed, in which event the regulation, unless withdrawn, becomes effective on the date specified, which shall be after the expiration of the twenty-one day extension period; or (ii) the Governor exercises his authority to suspend the regulatory process for solicitation of additional public comment, in which event the regulation, unless withdrawn, becomes effective on the date specified which date shall be after the expiration of the period for which the Governor has suspended the regulatory process.

Proposed action on regulations may be withdrawn by the promulgating agency at any time before final action is taken.

EMERGENCY REGULATIONS

If an agency determines that an emergency situation exists, it then requests the Governor to issue an emergency regulation. The emergency regulation becomes operative upon its adoption and filing with the Registrar of Regulations, unless a later date is specified. Emergency regulations are limited in time and cannot exceed a twelve-months duration. The emergency regulations will be published as quickly as possible in the *Virginia Register.*

During the time the emergency status is in effect, the agency may proceed with the adoption of permanent regulations through the usual procedures (See "Adoption, Amendment, and Repeal of Regulations," above). If the agency does not choose to adopt the regulations, the emergency status ends when the prescribed time limit expires.

STATEMENT

The foregoing constitutes a generalized statement of the procedures to be followed. For specific statutory language, it is suggested that Article 2 of Chapter 1.1:1 (§§ 9-6.14:6 through 9-6.14:9) of the Code of Virginia be examined carefully.

CITATION TO THE VIRGINIA REGISTER

The Virginia Register is cited by volume, issue, page number, and date. **1:3 VA.R. 75-77 November 12, 1984** refers to Volume 1, Issue 3, pages 75 through 77 of the Virginia Register issued on November 12, 1984.

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PUBLICATION DEADLINES AND SCHEDULES

September 1990 through December 1991

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Oct. 17	Nov. 5
Oct. 31	Nov. 19
Nov. 14	Dec. 3
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Symbol Key
Roman type indicates existing text of regulations. *Italic type* indicates proposed new text. Language which has been stricken indicates proposed text for deletion.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: **State Plan for Medical Assistance Relating to Long-Stay Acute Care Hospitals.**
VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality of Care.
VR 460-04-8.10. Long-Stay Acute Care Hospitals.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until May 24, 1991.
(See Calendar of Events section for additional information)

Summary:

The purpose of this proposal is to promulgate permanent regulations regarding authorization and utilization review processes in long-stay acute care hospitals, to supersede the temporary emergency regulations which became effective on August 8, 1990.

The proposed regulations affect both state regulations governing long stay acute care hospitals (VR 460-04-8.10) and the section of the State Plan for Medical Assistance dealing with Standards Established and Methods Used to Assure High Quality of Care (Attachment 3.1 C).

Long stay acute care hospitals provide specialized services to individuals who require more intensive medical management and nursing care than can normally be provided in nursing facilities. The proposed regulations establish criteria for use both during the admission process and during utilization review, to ensure that the intensive care services offered are appropriate to the patient in question. These criteria do not apply to long stay hospitals serving the mentally ill.

The criteria have been separated to accommodate the differing medical and habilitation needs of adult and pediatric/adolescent patient populations. The following are descriptions of the criteria for each of these categories.

1. Adult Long Stay Acute Care Hospital Criteria: The resident must have long-term health conditions requiring close medical supervision (defined as weekly physician visits), the need for 24-hour licensed nursing care, and the need for specialized services (defined as two out of these rehabilitation services: physical, occupational, speech-language therapies) or specialized equipment. The targeted population includes individuals requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, comprehensive rehabilitative therapy services, and individuals with communicable diseases requiring universal or respiratory precautions.

2. Pediatric/Adolescent Long stay Acute Care Hospital Criteria: The child (age 21 or younger) must have ongoing health care needs requiring close medical supervision (defined as weekly physician visits), 24-hour licensed nursing supervision, and specialized services (defined as two out of these rehabilitation services: physical, occupational, speech-language therapies) or equipment. The targeted population includes children requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, daily dependence on device-based respiratory or nutritional support (tracheostomy, gastrostomy, etc.), comprehensive rehabilitative therapy services, and children with communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.) or terminal illnesses.

In addition, the nursing facility must provide for age-appropriate educational and habilitative needs of children. These individualized services must be appropriate to the child's cognitive level, must meet state educational requirements, and be provided in an organized manner that encourages the child's participation. Services may include, but are not limited to, school, active treatment for mental retardation, habilitative therapies, social skills and leisure activities. Therapeutic leisure services must be provided daily.

The proposed regulations are substantively the same as the temporary emergency regulations promulgated on August 8, 1990 except for rehabilitative service limit requirements. Comments from regulated providers about these limits in the emergency regulation resulted in proposed language which affords the providers greater flexibility. Technical changes were made for clarity.

VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality of Care.

The following is a description of the standards and the methods that will be used to assure that the medical and

remedial care and services are of high quality:

§ 1. Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX.

§ 2. Utilization control.

A. Hospitals.

1. The Commonwealth of Virginia is required by state law to take affirmative action on all hospital stays that approach 15 days. It is a requirement that the hospitals submit to the Department of Medical Assistance Services complete information on all hospital stays where there is a need to exceed 15 days. The various documents which are submitted are reviewed by professional program staff, including a physician who determines if additional hospitalization is indicated. This review not only serves as a mechanism for approving additional days, but allows physicians on the Department of Medical Assistance Services' staff to evaluate patient documents and give the Program an insight into the quality of care by individual patient. In addition, hospital representatives of the Medical Assistance Program visit hospitals, review the minutes of the Utilization Review Committee, discuss patient care, and discharge planning.

2. In each case for which payment for inpatient hospital services, or inpatient mental hospital services is made under the State Plan:

a. A physician must certify at the time of admission, or if later, the time the individual applies for medical assistance under the State Plan that the individual requires inpatient hospital or mental hospital care.

b. The physician, or physician assistant under the supervision of a physician, must recertify, at least every 60 days, that patients continue to require inpatient hospital or mental hospital care.

c. Such services were furnished under a plan established and periodically reviewed and evaluated by a physician for inpatient hospital or mental hospital services.

B. Long-stay acute care hospitals (nonmental hospitals).

1. Services for adults in long-stay acute care hospitals. The population to be served includes individuals requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, comprehensive rehabilitative therapy services and individuals with communicable diseases requiring universal or respiratory precautions.

a. Admission criteria for long-stay acute care hospital stays require that the hospital submit a completed LTC Assessment Process Instrument (DMAS-95), a physician certification of the need for long-stay acute care hospital placement, and any additional information that justifies the need for intensive services. Prior authorization shall be required by submission of the DMAS-95. Physician certification must accompany the request. Periods of care not authorized by DMAS shall not be approved for payment.

b. These individuals must have long-term health conditions requiring close medical supervision, the need for 24-hour licensed nursing care, and the need for specialized services or equipment needs.

c. At a minimum, these individuals must require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is the designated unit must be on the nursing unit 24 hours a day on which the resident resides), and coordinated multidisciplinary team approach to meet needs.

d. In addition, the individual must meet at least one of the following requirements:

(1) Must require two out of three of the following rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, five days per week, for a minimum of one hour each day; individual must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

(2) Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by a licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy; or

(3) The individual must require at least one of the following special services:

(a) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(b) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only);

(c) Dialysis treatment that is provided on-unit (i.e. peritoneal dialysis);

(d) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(e) Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day

(i.e. grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body); or

(f) Ongoing management of multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e. suctioning every hour; stabilization of feeding; stabilization of elimination, etc.).

e. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the individuals' medical records as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

f. When the individual no longer meets long-stay acute care hospital criteria or requires services that the facility is unable to provide, then the individual must be discharged.

2. Services to pediatric/adolescent patients in long-stay acute care hospitals. The population to be served shall include children requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, daily dependence on device-based respiratory or nutritional support (tracheostomy, gastrostomy, etc.), comprehensive rehabilitative therapy services, and those children having communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.) and with terminal illnesses.

a. Long-stay acute care hospital stays shall be preauthorized by the submission of a completed LTC Assessment Process Instrument (DMAS-95), a physician certification of the need for long-stay acute care, and any additional information that justifies the need for intensive services. Periods of care not authorized by DMAS shall not be approved for payment.

b. The child must have ongoing health conditions requiring close medical supervision, the need for 24-hour licensed nursing supervision, and the need for specialized services or equipment. The recipient must be age 21 or under.

c. The child must minimally require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is that nursing unit must be on the unit 24 hours a day on which the child is residing), and a coordinated multidisciplinary team approach to meet needs.

d. In addition, the child must meet one of the following requirements:

(1) Must require two out of three of the following physical rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, fivedays per week, for a minimum of 45 minutes per day; child must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

(2) Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy, etc; or

(3) Must require at least one of the following special services:

(a) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(b) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only or isolation for normal childhood diseases such as measles, chicken pox, strep throat, etc.);

(c) Dialysis treatment that is provided within the facility (i.e. peritoneal dialysis);

(d) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(e) Extensive wound care requiring debridement, irrigation, packing, etc. more than two times a day (i.e. grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body);

(f) Ostomy care requiring services by a licensed nurse;

(g) Services required for terminal care.

e. In addition, the long-stay acute care hospital must provide for the educational and habilitative needs of the child. These services must be age appropriate, must meet state educational requirements, and must be appropriate to the child's cognitive level. Services must also be individualized to meet the child's specific needs and must be provided in an organized manner that encourages the child's participation. Services may include, but are not limited to, school, active treatment for mental retardation, habilitative therapies, social skills, and leisure activities. Therapeutic leisure activities must be provided daily.

f. Utilization review shall be performed to determine if services are appropriately provided and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

g. When the resident no longer meets long-stay hospital criteria or requires services that the facility is unable to provide, the resident must be discharged.

~~B.~~ *C.* Nursing ~~homes~~ *facilities* .

~~(Skilled and Intermediate Care Facility)~~

1. As required by federal law, the Department of Medical Assistance Services visits every Medicaid patient that is residing in a nursing home in Virginia. The purpose of the visit is to conduct a complete medical and social evaluation of the patient. The visit also includes patient interviews and discussions with the professional staff and the attending physician. Thus, it is assured that quality care is rendered to these recipients and that the patient is receiving the proper level of care.

2. Long term care of patients in medical institutions will be provided in accordance with procedures and practices that are based on the patient's medical and social needs and requirements.

3. In each case for which payment for ~~services, skilled~~ nursing facility services ~~or intermediate care facility services~~ is made under the State Plan:

a. A physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, must certify at the time of admission, or if later, the time the individual applies for medical assistance under the State Plan that the individual requires the ~~skilled or intermediate~~ *nursing facility* level of care. The Nursing Home Preadmission Screening shall serve as the admission or initial certification for ~~intermediate or skilled~~ nursing home care if the date of the screening occurred within 30 days prior to the admission;

b. The physician, or nurse practitioner or clinical nurse specialist, who is not an employee of the facility but is working in collaboration with a physician, must recertify the need for skilled or intermediate level of care. Recertifications must be written according to the following schedule:

(1) Skilled Nursing Facility Services - at least:

30 days after the date of the initial certification,

60 days after the date of the initial certification,

90 days after the date of the initial certification, and

every 60 days thereafter;

(2) Intermediate Nursing Home Care - at least:

60 days after the date of the initial certification,

180 days after the date of the initial certification,

12 months after the date of the initial certification,

18 months after the date of the initial certification,

24 months after the date of the initial certification, and

every 12 months thereafter;

(3) Intermediate Care Facilities for the Mentally Retarded - at least every 365 days;

c. For the purpose of determining compliance with the schedule established by paragraph b, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required, if the physician, or other person making such recertification, provides a written statement showing good cause why such recertification did not meet such schedule;

d. Such services were furnished under a plan established and periodically reviewed and evaluated by a physician or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but who is working in collaboration with a physician for skilled or intermediate care services ;

e. The schedule of recertifications set forth in paragraph b shall become effective for all admissions and recertifications due on or after October 1, 1984, except that this amendment made by this section shall not require recertifications sooner or more frequently than every 60 days for skilled care patients admitted before October 1, 1984;

f. The addition of the nurse practitioner or clinical nurse specialist, as qualified in paragraphs a, b, and d, shall apply to certifications, recertifications, and plans of care for skilled or intermediate care written on or after July 1, 1988, and before October 1, 1990;

g. The Department of Medical Assistance Services will recover payments made for periods of care in which the certifications, recertifications, and plans

of care documentation does not meet the time schedule of this section to the extent required by federal law.

h. In addition, a fiscal penalty of 1-1/2% per month of the disallowed payment will be assessed against the nursing home from the time the noncertified service was rendered until payment is received by the Virginia Medical Assistance Program (§ 32.1-313 of the Code of Virginia). No efforts by the nursing home shall be exerted to recoup this penalty from the patient or responsible party.

* * * *

PART I.
ADMISSION CRITERIA FOR REHABILITATIVE SERVICES.

§ 1.1. A patient qualifies for intensive inpatient or outpatient rehabilitation if:

A. Adequate treatment of his medical condition requires an intensive rehabilitation program consisting of a multi-disciplinary coordinated team approach to upgrade his ability to function as independently as possible; and

B. It has been established that the rehabilitation program cannot be safely and adequately carried out in a less intense setting.

§ 1.2. In addition to the initial disability requirement, participants shall meet the following criteria:

A. Require at least two of the listed therapies in addition to rehabilitative nursing:

1. Occupational Therapy

2. Physical Therapy

3. Cognitive Rehabilitation

4. Speech-Language Therapy

B. Medical condition stable and compatible with an active rehabilitation program.

PART II.
INPATIENT ADMISSION AUTHORIZATION.

§ 2.1. Within 72 hours of a patient's admission to an inpatient rehabilitation program, or within 72 hours of notification to the facility of the patient's Medicaid eligibility, the facility shall notify the Department of Medical Assistance Services in writing of the patient's admission. This notification shall include a description of the admitting diagnoses, plan of treatment, expected progress and a physician's certification that the patient meets the admission criteria. The Department of Medical Assistance Services will make a determination as to the appropriateness of the admission for Medicaid payment and notify the facility of its decision. If payment is approved, the Department will establish and notify the facility of an approved length of stay. Additional lengths of stay shall be reques ted in writing and approved by the Department. Admissions or lengths of stay not authorized by the Department of Medical Assistance Services will not be approved for payment.

PART III.
DOCUMENTATION REQUIREMENTS.

§ 3.1. Documentation of rehabilitation services shall, at a minimum:

A. Describe the clinical signs and symptoms of the patient necessitating admission to the rehabilitation program;

B. Describe any prior treatment and attempts to rehabilitate the patient;

C. Document an accurate and complete chronological picture of the patient's clinical course and progress in treatment;

D. Document that a multi-disciplinary coordinated treatment plan specifically designed for the patient has been developed;

E. Document in detail all treatment rendered to the patient in accordance with the plan with specific attention to frequency, duration, modality, response to treatment, and identify who provided such treatment;

F. Document each change in each of the patient's conditions;

G. Describe responses to and the outcome of treatment; and

H. Describe a discharge plan which includes the anticipated improvements in functional levels, the time frames necessary to meet these goals, and the patient's discharge destination.

§ 3.2. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no coverage will be provided.

PART IV.
INPATIENT REHABILITATION EVALUATION.

§ 4.1. For a patient with a potential for rehabilitation for which an outpatient assessment cannot be adequately performed, an inpatient evaluation of no more than seven calendar days will be allowed. A comprehensive assessment will be made of the patient's medical condition, functional limitations, prognosis, possible need for corrective surgery, attitude toward rehabilitation, and the

existence of any social problems affecting rehabilitation. After these assessments have been made, the physician, in consultation with the rehabilitation team, shall determine and justify the level of care required to achieve the stated goals.

§ 4.2. If during a previous hospital stay an individual completed a rehabilitation program for essentially the same condition for which inpatient hospital care is now being considered, reimbursement for the evaluation will not be covered unless there is a justifiable intervening circumstance which necessitates a re-evaluation.

§ 4.3. Admissions for evaluation and/or training for solely vocational or educational purposes or for developmental or behavioral assessments are not covered services.

PART V.
CONTINUING EVALUATION.

§ 5.1. Team conferences shall be held as needed but at least every two weeks to assess and document the patient's progress or problems impeding progress. The team shall periodically assess the validity of the rehabilitation goals established at the time of the initial evaluation, and make appropriate adjustments in the rehabilitation goals and the prescribed treatment program. A review by the various team members of each others' notes does not constitute a team conference. A summary of the conferences, noting the team members present, shall be recorded in the clinical record and reflect the reassessments of the various contributors.

§ 5.2. Rehabilitation care is to be terminated, regardless of the approved length of stay, when further progress toward the established rehabilitation goal is unlikely or further rehabilitation can be achieved in a less intensive setting.

PART VI.
THERAPEUTIC FURLOUGH DAYS.

§ 6.1. Properly documented medical reasons for furlough may be included as part of an overall rehabilitation program. Unoccupied beds (or days) resulting from an overnight therapeutic furlough will not be reimbursed by the Department of Medical Assistance Services.

PART VII.
DISCHARGE PLANNING.

§ 7.1. Discharge planning shall be an integral part of the overall treatment plan which is developed at the time of admission to the program. The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination. The patient, unless unable to do so, or the responsible party shall participate in the discharge planning. Notations concerning changes in the discharge plan shall be entered into the record at least every two weeks, as a part of the team conference.

PART VIII.

REHABILITATION SERVICES TO PATIENTS.

§ 8.1. Rehabilitation services are medically prescribed treatment for improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. The rules pertaining to them are:

A. Rehabilitative nursing.

Rehabilitative nursing requires education, training, or experience that provides special knowledge and clinical skills to diagnose nursing needs and treat individuals who have health problems characterized by alteration in cognitive and functional ability.

Rehabilitative nursing are those services furnished a patient which meet all of the following conditions:

1. The services shall be directly and specifically related to an active written treatment plan approved by a physician after any needed consultation with a registered nurse who is experienced in rehabilitation;

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a registered nurse or licensed professional nurse, nursing assistant, or rehabilitation technician under the direct supervision of a registered nurse who is experienced in rehabilitation;

3. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

4. The service shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative nursing services which can only be provided in an intensive rehabilitation setting.

B. Physical therapy.

1. Physical therapy services are those services furnished a patient which meet all of the following conditions:

a. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a qualified physical therapist licensed by the Board of Medicine;

c. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

d. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

C. Occupational therapy.

1. Occupational therapy services are those services furnished a patient which meet all of the following conditions:

a. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board;

b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Certification Board under the direct supervision of a qualified occupational therapist as defined above;

c. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

d. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

D. Speech-Language therapy.

1. Speech-Language therapy services are those services furnished a patient which meet all of the following conditions:

a. The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology;

c. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

d. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

E. Cognitive rehabilitation.

1. Cognitive rehabilitation services are those services furnished a patient which meet all of the following conditions:

a. The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a clinical psychologist experienced in working with the neurologically impaired and licensed by the Board of Medicine;

b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be rendered after a neuropsychological evaluation administered by a clinical psychologist or physician experienced in the administration of neuropsychological assessments and licensed by the

Board of Medicine and in accordance with a plan of care based on the findings of the neuropsychological evaluation;

c. Cognitive rehabilitation therapy services may be provided by occupational therapists, speech-language pathologists, and psychologists who have experience in working with the neurologically impaired when provided under a plan recommended and coordinated by a physician or clinical psychologist licensed by the Board of Medicine;

d. The cognitive rehabilitation services shall be an integrated part of the total patient care plan and shall relate to information processing deficits which are a consequence of and related to a neurologic event;

e. The services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning, memory, discrimination and behavior; and

f. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis.

F. Psychology.

1. Psychology services are those services furnished a patient which meet all of the following conditions:

a. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified psychologist as required by state law;

c. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

d. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

G. Social work.

1. Social work services are those services furnished a patient which meet all of the following conditions:

a. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified social worker as required by state law;

c. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

d. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

H. Recreational therapy.

1. Recreational therapy are those services furnished a patient which meet all of the following conditions:

a. The services shall be directly and specifically related to an active written treatment plan ordered by a physician;

b. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services are performed as an integrated part of a comprehensive rehabilitation plan of care by a recreation therapist certified with the National Council for Therapeutic Recreation at the professional level;

c. The services shall be provided with the expectation, based on the assessment made by the physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

d. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of practice; this includes the requirement that the amount, frequency and duration of the services shall be reasonable.

I. Prosthetic/orthotic services.

1. Prosthetic services furnished to a patient include prosthetic devices that replace all or part of an external body member, and services necessary to design the device, including measuring, fitting, and instructing the patient in its use;

2. Orthotic device services furnished to a patient include orthotic devices that support or align extremities to prevent or correct deformities, or to improve functioning, and services necessary to design the device, including measuring, fitting and instructing the patient in its use; and

3. Maxillofacial prosthetic and related dental services are those services that are specifically related to the improvement of oral function not to include routine oral and dental care.

4. The services shall be directly and specifically related to an active written treatment plan approved by a physician after consultation with a prosthetist, orthotist, or a licensed, board eligible prosthodontist, certified in Maxillofacial prosthetics.

5. The services shall be provided with the expectation, based on the assessment made by physician of the patient's rehabilitation potential, that the condition of the patient will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance.

6. The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical and dental practice; this includes the requirement that the amount, frequency, and duration of the services be reasonable.

J. Durable medical equipment.

1. Durable medical equipment furnished the patient receiving approved covered rehabilitation services is covered when the equipment is necessary to carry out an approved plan of rehabilitation. A rehabilitation hospital or a rehabilitation unit of a hospital enrolled with Medicaid under a separate provider agreement for rehabilitative services may supply the durable medical equipment. The provision of the equipment is to be billed as an outpatient service. All durable medical equipment over $1,000 shall be preauthorized by the department; however, all durable medical equipment is subject to justification of need. Durable medical equipment normally supplied by the hospital for inpatient care is not covered by this provision.

VR 460-04-8.10. Regulation for Long-Stay Acute Care Hospitals.

§ 1. Scope.

Medicaid shall cover long-stay acute care hospital services as defined in § 2 provided by hospitals certified as long-stay acute care hospitals and which have provider agreements with the Department of Medical Assistance Services.

§ 2. Authorization for services.

Long-stay acute care hospital stays shall be preauthorized by the submission of a completed DMAS-95, a physician certification of the need for long-stay acute care hospital placement, and any additional information that justifies the need for intensive services. Prior authorization shall be required by submission of the DMAS-95. Physician certification must accompany the request. Periods of care not authorized by the Department of Medical Assistance Services shall not be approved for payment.

§ 3. Criteria for long-stay acute care hospital stays.

A. Adult long-stay acute care hospital criteria.

1. The resident must have long-term health conditions requiring close medical supervision, 24-hour licensed nursing care, and specialized services or equipment needs. The population to be served includes individuals requiring mechanical ventilation, individuals with communicable diseases requiring universal or respiratory precautions, individuals requiring ongoing intravenous medication or nutrition administration, and individuals requiring comprehensive rehabilitative therapy services.

2. At a minimum, the individual must require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is the designated unit must be on the nursing unit on which the resident resides, 24 hours a day), and coordinated multidisciplinary team approach to meet needs.

3. In addition, the individual must meet at least one of the following requirements:

a. Must require two out of three of the following rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, five days per week, for a minimum of one hour each day; individual must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

b. Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by a licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy; or

c. The individual must require at least one of the following special services:

(1) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(2) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only);

(3) Dialysis treatment that is provided on-unit (i.e. peritoneal dialysis);

(4) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(5) Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e. grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body); or

(6) Multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e. suctioning every hour, stabilization of feeding, stabilization of elimination, etc.)

B. Pediatric/adolescent patients in long-stay acute care hospitals criteria.

1. To be eligible for long-stay acute care hospital services, the child must have ongoing health conditions requiring close medical supervision, 24-hour licensed nursing supervision, and specialized services or equipment needs. The recipient must be age 21 or under. The population to be served includes children requiring mechanical ventilation, those with communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.), those requiring ongoing intravenous medication or nutrition administration, those requiring daily dependence on device-based respiratory or nutritional support (tracheostomy, gastrostomy, etc.), those requiring comprehensive rehabilitative therapy services, and those with a terminal illness.

2. The child must minimally require physician visits at least once weekly, licensed nursing services 24 hours a day (a registered nurse whose sole responsibility is that nursing unit must be on the unit on which the child is residing 24 hours a day), and a coordinated multidisciplinary team approach to meet needs.

3. In addition, the child must meet one of the following requirements:

a. Must require two out of three of the following physical rehabilitative services: physical therapy, occupational therapy, speech-pathology services; each required therapy must be provided daily, five days per week, for a minimum of 45 minutes per day; child must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or

b. Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac), kinetic therapy, etc; or

c. Must require at least one of the following special services:

(1) Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);

(2) Special infection control precautions such as universal or respiratory precaution (this does not include handwashing precautions only or isolation for normal childhood diseases such as measles, chicken pox, strep throat, etc.);

(3) Dialysis treatment that is provided within the facility (i.e. peritoneal dialysis);

(4) Daily respiratory therapy treatments that must be provided by a licensed nurse or a respiratory therapist;

(5) Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body);

(6) Ostomy care requiring services by a licensed nurse;

(7) Services required for terminal care.

4. In addition, the long-stay acute care hospital must provide for the educational and habilitative needs of the child. These services must be age appropriate, must meet state educational requirements, and must be appropriate to the child's cognitive level. Services must also be individualized to meet the specific needs of the child and must be provided in an organized manner that encourages the child to participate. Services may include, but are not limited to, school,

active treatment for mental retardation, habilitative therapies, social skills, and leisure activities. Therapeutic leisure activities must be provided daily. The services must be provided for a minimum of two hours per day.

§ 4. Documentation requirements.

A. Services not specifically documented in the resident's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

B. The long-stay acute care hospital shall maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records shall be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer, except that, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.

C. The following documentation must be maintained in the resident's medical record:

1. Each record must identify the resident on each page.

2. Entries must be signed and dated (month, day, and year) by the author, followed by professional title. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

3. The attending physician must certify at the time of admission that the resident requires long-stay acute hospital care and meets the criteria as defined by DMAS.

4. The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.

5. All services provided, as well as any treatment plan, must be entered in the record. Any drugs prescribed and administered as part of a physician's treatment plan, including the quantities, route of administration, and the dosage must be recorded.

6. The record must indicate the resident's progress, any change in diagnosis or treatment, and the response to the treatment.

7. Physician progress notes must be written at least weekly and must reflect that the resident has been examined by the physician.

8. A comprehensive nursing assessment must be made by a registered nurse at the time of admission to the facility. Nursing care plans based on an admission assessment must be resident-specific and must indicate realistic nursing needs, measurable goals, and specifically state the method by which the goals are to be accomplished. They must be updated as needed, but at least monthly. Nursing summaries, in addition to the p.r.n. (as needed) notes, are required weekly. Nursing summaries must give a current, written picture of the resident, the resident's nursing needs, the care being provided, and the resident's response to treatment. The nursing summary at a minimum must address the following: medical status; functional status in activities of daily living, elimination, mobility, and emotional/mental status; special nursing procedures; and identification and resolution of acute illnesses or episodes.

9. Social services documentation must include a social evaluation and history and a social services plan of care including a discharge plan. The social work plans of care must be resident-specific and include measurable goals with realistic time frames. Social work plans of care must be updated as needed and at least monthly every 30 days. Social services progress notes must be written at least every 30 days.

10. Activities documentation must be based on a comprehensive assessment completed by the designated activity coordinator. An activity plan of care must be developed for each resident and must include consideration of the individual's interests and skills, the physician's recommendations, social and rehabilitation goals, and personal care requirements. Individual and group activities must be included in the plan. The activity plan of care must be updated as needed but at least every 30 days. Activity progress notes must be written at least every 30 days.

11. Rehabilitative therapy (physical and occupational therapy or speech-language services) or other health care professional (psychologist, respiratory therapist, etc.) documentation must include an assessment completed by the qualified rehabilitation professional. A plan of care developed specific to the resident must be developed and must include measurable goals with realistic time frames. The plan of care must be updated as needed but at least every 30 days. Rehabilitative therapy or other health care professional progress notes must be written at least every 30 days.

12. Each resident's record must contain a dietary evaluation and plan of care completed by a registered dietician. The plan of care must be resident-specific and must have measurable goals within realistic time frames. The plan of care must be updated as needed, but at least every 30 days. The dietary assessment and monthly plans of care must be completed by a registered dietician. Dietary progress notes must be written at least every 30 days.

13. A coordinated interdisciplinary plan of care must be developed for each resident. The plan of care must be resident-specific and must contain measurable goals within realistic time frames. Based on the physician's plan of care, the interdisciplinary team should include, but is not necessarily limited to, nurses, social workers, activities coordinators, dieticians, rehabilitative therapists, direct care staff, and the resident or responsible party. At a minimum, the interdisciplinary team must review and update the interdisciplinary plan of care as needed but at least every 30 days. The interdisciplinary plan of care review must identify those attending the meeting, changes in goals and approaches, and progress made toward meeting established goals and discharge.

14. For residents age 21 and younger, the record must contain documentation that educational or habilitative services are provided as required. The documentation shall include an evaluation of the resident's educational or habilitative needs, a description of the educational or habilitative services provided, a schedule of planned programs, and records of resident attendance. Educational or habilitative progress notes shall be written at least every 30 days.

§ 5. Long-stay acute care hospital services.

All services must be provided by appropriately qualified personnel. The following services are covered long-stay acute care hospital services:

A. Physician services.

1. Physician services shall be performed by a professional who is licensed to practice in the Commonwealth, who is acting within the scope of his license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.

2. An attending physician means a physician who is a doctor of medicine or osteopathy and is identified by the individual as having the most significant role in the determination and delivery of the individual's medical care.

B. Licensed nursing services.

1. Must be provided 24 hours a day (a registered nurse, whose sole responsibility is the designated unit on which the resident resides, must be on the unit 24 hours a day).

2. Nursing services shall be of a level of complexity and sophistication, or the condition of the resident shall be of a nature, that the services can only be performed by a registered nurse or licensed professional nurse, or nursing assistant under the direct supervision of a registered nurse who is experienced in providing the specialized care required by the resident.

C. Rehabilitative services.

1. Rehabilitative services shall be directly and specifically related to written plan of care designed by a physician after any needed consultation with the rehabilitation professional.

2. Physical therapy services shall be of a level of complexity and sophistication, or the condition of the resident shall be of a nature, that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a physical therapist licensed by the Board of Medicine.

3. Occupational therapy services shall be of a level of complexity and sophistication, or the condition of the resident shall be of a nature, that the services can only be performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Certification Board under the direct supervision of an occupational therapist as defined.

4. Speech-language services shall be of a level of complexity and sophistication, or the condition of the resident shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology.

D. Ancillary services shall be provided directly and specifically related to a plan of care designed by the physician. The ancillary services may include but are not limited to dietary, respiratory therapy services, and psychological services.

1. Dietary services must be of a level of complexity or sophistication, or the nature of the resident shall be of a nature that the services can only be performed or supervised by a dietician, registered with the American Dietetic Association.

2. Respiratory therapy services must be of a level of complexity and sophistication, or the nature of the resident shall be of a nature that the services can only be performed by a respiratory therapist. Respiratory therapy services must be provided by a respiratory therapist certified by the Board of Medicine or registered with the National Board for Respiratory Care. If the facility agrees to provide care to a resident who is dependent on mechanical assistance for respiration (positive or negative pressure mechanical ventilators), respiratory therapy services must be available 24 hours daily. If the facility

contracts for respiratory therapy services, a respiratory therapist must be on call 24 hours daily and available to the facility in a timely manner.

3. Psychology services shall be of a level of complexity or sophistication, or the condition shall be of a nature that the services can only be performed by a psychologist licensed by the Board of Medicine.

4. Activity programs under the supervision of designated activities coordinators. The program of activities must include both individual and group activities which are based on consideration of interest, skills, physical and mental status, and personal care requirements.

5. Provide social services to each resident in an effort to assist the resident, his family and the nursing facility staff in understanding the significant social and emotional factors related to the health problems, to assist with appropriate utilization of community resources and to coordinate discharge plans. Social services must be provided by a social worker with at least a bachelor's degree in social work or similar qualifications.

§ 6. Long-stay acute care hospital requirements.

A. A coordinated multidisciplinary team approach shall be implemented to meet the needs of the resident. Based on the physician's plan of care, the interdisciplinary team should include, but is not necessarily limited to, nurses, social workers, activity coordinators, dieticians, rehabilitative therapists, and any direct care staff.

B. The long-stay acute care hospital shall provide for the educational and habilitative needs of residents age 21 or younger. These services must be age appropriate, must meet state educational requirements, and must be appropriate to the child's cognitive level. Services must be individualized to meet the specific needs of the child and must be provided in an organized manner which encourages the child to participate. Services may include but are not limited to school, active treatment for mental retardation, habilitative therapies, social skills and leisure activities. Therapeutic leisure activities must be provided daily.

C. The long-stay acute care hospital shall provide an acceptable plan for assuring that residents requiring long-stay acute hospital care are afforded the same opportunity for participating in integrated facility activities as the other facility residents.

D. Nonemergency transportation shall be provided so that residents may participate in community activities sponsored by the facility or community activities in which the facility is providing transportation for other facility residents.

E. The long-stay acute care hospital shall coordinate discharge planning for the resident utilizing all available resources in an effort to assist the resident to maximize his potential for independence and self-sufficiency and to assure that services are being provided by the most effective level of care.

F. The long-stay acute care hospital shall provide family or caregiver training in the skills necessary for the care of the resident in the community, should the resident or the resident's caregiver so desire.

G. The long-stay acute care hospital shall provide all necessary durable medical equipment to sustain life or monitor vital signs and to carry out a plan of care designed by the physician. This equipment may include but is not limited to mechanical ventilator, apnea monitor, etc.

H. The long-stay acute care hospital shall provide utilization review activities as follows:

1. Purpose. The objective of the utilization review mechanism is the maintenance of high-quality patient care and the most efficient utilization of resources through an educational approach involving the study of patient care as well as to ensure that inpatient care is provided only when medically necessary and that the care meets quality standards.

a. In addition to the certification by the resident's physician, the hospital shall have a utilization review plan which provides for review of all Medicaid patient stays and medical care evaluation studies of admissions, durations of stay, and professional services rendered.

b. Effective utilization review shall be maintained on a continuing basis to ensure the medical necessity of the services for which the program pays and to promote the most efficient use of available health facilities and services.

2. The Department of Medical Assistance Services delegates to the local facilities' utilization review departments the utilization review of inpatient hospital services for all Medicaid admissions. The hospital must have a utilization review plan reflecting 100% review of Medicaid residents, approved by the Division of Licensure and Certification of the Department of Health, and DMAS or the appropriate licensing agency in the state in which the institution is licensed.

3. The hospital utilization review coordinator shall approve the medical necessity, based on admission criteria approved by the utilization review committee, within one working day of admission. In the event of an intervening Saturday, Sunday, or holiday, a review must be performed the next working day. This review shall be reflected in the hospital utilization review plan and the resident's record.

4. If the admission is determined medically necessary, an initial stay review date must be assigned and reflected on the utilization review sheets. Continued or extended stay review must be assigned prior to or on the date assigned for the initial stay. If the facility's utilization review committee has reason to believe that an inpatient admission was not medically necessary, it may review the admission at any time. However, the decision of a utilization review committee in one facility shall not be binding upon the utilization review committee in another facility.

5. If the admission or continued stay is found to be medically unnecessary, the attending physician shall be notified and be allowed to present additional information. If the hospital physician advisor still finds the admission or continued stay unnecessary, a notice of adverse decision must be made within one working day after the admission or continued stay is denied. Copies of this decision must be sent by the utilization review committee's designated agent to the hospital administrator, attending physician, recipient or recipient's authorized representative, and Medicaid.

6. As part of the utilization review plan, long-stay acute care hospitals shall have one medical or patient care evaluation study in process and one completed each calendar year. Medical care evaluation studies must contain the elements mandated by 42 CFR 456.141 through 456.145. The elements are objectives of study, results of the study, evaluation of the results, and action plan or recommendations as indicated by study results.

7. The Department of Medical Assistance Services shall monitor the length of stay for inpatient hospital stays. The guidelines used shall be based on the criteria described in § 3 of these regulations. If the stay or any portion of the stay is found to be medically unnecessary, contrary to program requirements, or if the required documentation has not been received, reimbursement will not be made by Medicaid.

8. Services not specifically documented in the patient's medical record as having been rendered shall be deemed not to have been rendered and no coverage shall be provided.

I. The long-stay acute care hospital shall provide all medical supplies necessary to provide care as directed by the physician's plan of care for the resident. These supplies may include but are not limited to suction catheters, tracheostomy care supplies, oxygen, etc.

J. The long-stay acute care hospital shall provide all nutritional elements including those that must be administered intravenously. This includes providing all necessary equipment or supplies necessary to administer the nutrients.

K. The long-stay acute care hospital shall submit all necessary health care and medical social service information on the resident to DMAS for preadmission authorization. The provider cannot bill DMAS for services that have not been preauthorized.

ASSESSMENT PROCESS

NAME | HOME ADDRESS | TELEPHONE NUMBER

SUMMARY OF PROVIDERS

RECORD NUMBER	PROVIDER NAME	PROVIDER ADDRESS	TELEPHONE NUMBER	PROVIDER NUMBER	PROVIDER SOURCE	DATES OF ADMISSION	DATES OF DISCHARGE

BIRTHDATE (MONTH / DAY / YEAR)

BIRTHPLACE (SPECIFY STATE OR COUNTRY) ☐ USA₀ ☐ OTHER₁ _____

SEX ☐ MALE₀ ☐ FEMALE₁

MARITAL STATUS (Length of Time) ☐ MARRIED₀ ☐ SEPARATED₂ ☐ SINGLE₄ ☐ WIDOWED₁ ☐ DIVORCED₃ ☐ UNKNOWN₆

RELIGIOUS PREFERENCE
☐ CATHOLIC₀ ☐ OTHER₃,₈ _____
☐ JEWISH¹-SECT _____
☐ PROTESTANT²—SECT _____

RACIAL/ETHNIC BACKGROUND
☐ AMERICAN INDIAN OR ALASKAN NATIVE₉ ☐ BLACK₂ (NOT HISPANIC) ☐ WHITE₄ (NOT HISPANIC)
☐ ASIAN OR PACIFIC ISLANDER₇ ☐ HISPANIC₅ ☐ OTHER₅ _____

EDUCATION
☐ GRADUATE ☐ ELEM. s/HIGH SCHOOL COLLEGE₆ GRADES COMPLETED _____
☐ UNDERGRADUATE COLLEGE ☐ SPECIAL EDUCATION₇ Degree₁ or yrs.₂ _____
☐ TRADE, TECHNICAL VOCATIONAL₃ ☐ NO SCHOOLING₈
☐ HIGH SCHOOL DIPLOMA₄ ☐ UNKNOWN₉

FAMILY INCOME
☐ $20,000 OR MORE₀ ☐ $3,600 - $4,999₄
☐ $15,000 - $19,999₁ ☐ $2,600 - $3,599₅
☐ $10,000 - $14,999₂ ☐ $2,599 OR LESS₆
☐ $5,000 - $9,999₃ ☐ UNKNOWN₉

HEALTH CARE COVERAGE
☐ MEDICARE₁ # _____ PARTS☐ A₂ ☐ B
☐ MEDICAID₁ # _____
☐ OTHER₁ TYPE₁,₈ _____ # _____
☐ VETERAN₀ ☐ NON-VETERAN₁ ☐ UNKNOWN₈
SOCIAL SECURITY # _____

NONINSTITUTIONAL LIVING SPACE
☐ AVAILABLE₀ ☐ NOT AVAILABLE₁ ☐ NOT APPLICABLE₂

YES₀	NO₁	
		ENTRY STAIRS
		ELEVATOR OR OTHER CONVEYANCE AVAILABLE
		TOILET ROOM SAME FLOOR LEVEL AS BEDROOM
		KITCHEN SAME FLOOR LEVEL AS BEDROOM
		OTHER CONDITION

USUAL LIVING ARRANGEMENTS

	ALONE₁	SPOUSE₂	OTHER₃,₇
☐ HOME/APARTMENT₀			
☐ RENTED ROOM(S)₁			

☐ DOMICILIARY/PERSONAL CARE FACILITY₂₀
☐ HEALTH CARE FACILITY₃ -TYPE₁,₅ _____
☐ OTHER₄₀ _____

NUMBER OF LIVING CHILDREN _____
SON(S) _____ DAUGHTER(S) _____

SOCIAL SUPPORT WILLING AND ABLE TO PROVIDE

YES₁	NO₀		TIMES AVAILABLE
		ACTIVITIES OF DAILY LIVING/ SUPERVISION	
		HOUSEKEEPING	
		LIVING SPACE	
		MEAL PREPARATION	
		SHOPPING	
		TRANSPORTATION	
		OTHER	

EMPLOYMENT STATUS
☐ EMPLOYED₀ ☐ RETIRED₂
☐ PRE-RETIREMENT₁ ☐ PENSION₁
☐ POST-RETIREMENT₂,₃ ☐ NO PENSION₂
☐ UNEMPLOYED₁₀ ☐ NEVER EMPLOYED₃₀
☐ UNKNOWN₉₉

USUAL OCCUPATION
☐ HOMEMAKER₁₀ ☐ NONE₀₀
☐ OCCUPATION OUTSIDE THE HOME₂ SPECIFY₁,₇ _____

DIRECTORY OF HEALTH CARE PROFESSIONALS & OTHERS

NAME / ADDRESS / TELEPHONE NUMBER	DATES OF ASSESSMENT	TYPE OF SERVICE OR LEVEL OF CARE CURRENT	TYPE OF SERVICE OR LEVEL OF CARE RECOMMENDED	METHOD OF PAYMENT CURRENT	METHOD OF PAYMENT EXPECTED
REFERRING PHYSICIAN		0,7	0,8	0,8	0,8
ATTENDING PHYSICIAN					
ALTERNATE PHYSICIAN					
DENTIST					
PODIATRIST					
PHARMACY					
FUNERAL HOME					
PERSON(S) TO BE NOTIFIED					
OTHER					

UTILIZATION INFORMATION

LONG-TERM CARE INFORMATION SYSTEM SM
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1 FORMAT A

MEDICAL STATUS

CHECK BOXES WHICH APPLY. FILL IN SPACES AS INDICATED

	NO IMPAIRMENT₀	IMPAIRMENT (ATTEMPTED)₂ COMPENSATION₁ SPECIFY	NO COMPENSATION₃	COMPLETE LOSS₄	DATE OF CHANGE (IF ANY)
SIGHT			D		
HEARING			D		

SPEECH
☐ NO IMPAIRMENT₀₀
☐ IMPAIRMENT₁
☐ STRUCTURE OR MUSCULATURE OF VOCAL TRACT₂ TYPE _____
☐ LINGUISTIC SYSTEM₃
☐ COMPLETE LOSS₅
☐ DOES NOT SPEAK—NO KNOWN IMPAIRMENT₆

PREVIOUS REHABILITATION	COMPLETED₁ ONSET More Than 6 Months	COMPLETED₁ ONSET 6 Months Or Less	NOT COMPLETED₂ ONSET More Than 6 Months	NOT COMPLETED₂ ONSET 6 Months Or Less
	1	2	3	4
				D
				D

DENTITION

	COMPENSATION TYPE 1	COMPENSATION NONE 2	DATE OF CHANGE
☐ NO TEETH MISSING OR FEW TEETH MISSING₀₀			
☐ SOME OPPOSING TEETH₁		D	
☐ NO TEETH OR NO OPPOSING TEETH₂		D	

FRACTURES/DISLOCATIONS ☐ NONE₀₀₀

	LOCATION/ TREATMENT	PREVIOUS REHABILITATION PROGRAM YES₁	PREVIOUS REHABILITATION PROGRAM NO OR NOT COMPLETED₂	ONSET MORE THAN ONE YEAR₁	ONSET ONE YEAR OR LESS₄
HIP FRACTURE₁(S)₂			D		D
OTHER FRACTURE(S)₃					
DISLOCATION(S)₄					

MISSING LIMBS ☐ NONE₀₀₀

	LOCATION	PREVIOUS REHABILITATION PROGRAM YES₁	PREVIOUS REHABILITATION PROGRAM NO OR NOT COMPLETED₂	ONSET MORE THAN ONE YEAR₁	ONSET ONE YEAR OR LESS₂
FINGER(S) OR TOE(S)₁			D		
BELOW ELBOW₂			D		
ABOVE ELBOW₃			D		
BELOW KNEE₄			D		
ABOVE KNEE₅			D		

PARALYSIS/PARESIS ☐ NONE₀₀₀

	LOCATION	PREVIOUS REHABILITATION PROGRAM YES₁	PREVIOUS REHABILITATION PROGRAM NO OR NOT COMPLETED₂	ONSET MORE THAN ONE YEAR₁	ONSET ONE YEAR OR LESS₂
MONOPLEGIA/ PARESIS₁			D		D
HEMIPLEGIA/ PARESIS₂			D		D
PARAPLEGIA/ PARESIS₃			D		D
TRIPLEGIA/ PARESIS₄			D		D
BILATERAL HEMIPLEGIA/PARESIS₅			D		D
QUADRIPLEGIA/ PARESIS₆			D		D

ALLERGIES—SPECIFY ICD-9CM CODE

FAMILY HISTORY ICD-9CM CODE

NAME OR NUMBER

DIAGNOSES ICD-9CM CODE | DATE OF ONSET

RISK FACTOR MEASUREMENTS/OTHER TESTS

ALCOHOL/SUBSTANCE USE ☐ BY HISTORY - NOT AT PRESENT
☐ NO ☐ YES Type _____ Amount _____ ☐ UNKNOWN

TOBACCO USE ☐ NEVER USED ☐ BY HISTORY-NOT AT PRESENT
☐ CIGARETTES Specify _____
☐ PIPE Amount _____
☐ CHEWING Per Day _____

	RECORD DATE AND READING			
HEIGHT				
WEIGHT-IDEAL _____				
BLOOD PRESSURE				
BLOOD CHOLESTEROL				
BUN				
ALBUMINURIA				
BLOOD SUGAR-SPECIFY TEST				
HEMOGLOBIN OR HEMATOCRIT				
DIG. LEVEL SPECIFY TEST				
PROTHROMBIN TIME				
SERUM POTASSIUM				
CHEST X-RAY₁,₂ OTHER				

JOINT MOTION SPECIFY JOINTS AFFECTED

DATE				
WITHIN NORMAL LIMITS₀				
LIMITED MOTION₁ d				
INSTABILITY—CORRECTED₂				
INSTABILITY—UNCORRECTED₃ D				
IMMOBILITY₄ D				

MEDICAL HISTORY ICD-9CM CODE

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2 FORMAT A-1

FUNCTIONING STATUS

MH = MECHANICAL HELP
HH = HUMAN HELP

NAME OR NUMBER

ACTIVITIES OF DAILY LIVING (ADL)

BATHING
DATE
- WITHOUT HELP 0
- MH ONLY 1
- HH ONLY 2 D
- MH AND HH 3 D
- IS BATHED 4 OR DOES NOT BATHE 5 D
- DESCRIBE HELP

DRESSING
- WITHOUT HELP 0
- MH ONLY 1
- HH ONLY 2 D
- MH AND HH 3 D
- IS DRESSED 4 D
- IS NOT DRESSED 5 D
- DESCRIBE HELP

TOILETING
- WITHOUT HELP 0 DAY & NIGHT
- MH ONLY 1
- HH ONLY 2 D
- MH AND HH 3 D
- DOES NOT USE 4 TOILET ROOM D
- DESCRIBE HELP

TRANSFERRING
- WITHOUT HELP 0
- MH ONLY 1
- HH ONLY 2 D
- MH AND HH 3 D
- IS TRANSFERRED 4 D
- IS NOT TRANSFERRED 5 D
- DESCRIBE HELP

BOWEL FUNCTION
- CONTINENT 0
- INCONTINENT 1 LESS THAN WEEKLY
- OSTOMY-SELF CARE 2
- INCONTINENT 3 D WEEKLY OR MORE
- OSTOMY - NOT SELF CARE 4 D
- TYPE OF OSTOMY, OTHER PROBLEM 5

BLADDER FUNCTION
DATE
- CONTINENT 0
- INCONTINENT 1 LESS THAN WKLY
- EXTERNAL DEVICE SELF CARE 2
- INDWELLING CATHETER SELF CARE 3
- OSTOMY SELF CARE 4
- INCONTINENT 5 D WEEKLY OR MORE
- EXTERNAL DEVICE NOT SELF CARE 6 D
- INDWELLING CATHETER NOT SELF CARE 7 D
- OSTOMY NOT SELF CARE 8 D
- TYPE OF OSTOMY, OTHER PROBLEM

EATING/FEEDING
- WITHOUT HELP 0
- MH ONLY 1
- HH ONLY 2 D
- MH AND HH 3 D
- SPOON FED 4 D
- SYRINGE OR TUBE FED 5 D
- FED BY IV OR CLYSIS 6 DD
- DESCRIBE HELP

BEHAVIOR PATTERN
- APPROPRIATE 0 I
- WANDERING/PASSIVE LESS THAN WEEKLY 1 I
- WANDERING/PASSIVE WEEKLY OR MORE 2 d
- ABUSIVE/AGGRESSIVE/ DISRUPTIVE— LESS THAN WEEKLY 3 D
- ABUSIVE/AGGRESSIVE/ DISRUPTIVE— WEEKLY OR MORE 4 DD
- COMATOSE 5
- TYPE OF INAPPROPRIATE BEHAVIOR

ORIENTATION
- ORIENTED 0 I
- DISORIENTED - SOME SPHERES SOME TIME 1 d
- DISORIENTED - SOME SPHERES ALL TIME 2 d
- DISORIENTED - ALL SPHERES SOME TIME 3 D
- DISORIENTED - ALL SPHERES ALL TIME 4 D
- COMATOSE 5
- SPHERES AFFECTED

MOBILITY LEVEL
DATE
- GOES OUTSIDE WITHOUT HELP 0
- GOES OUTSIDE MH ONLY 1 d
- GOES OUTSIDE HH ONLY 2 D
- GOES OUTSIDE MH AND HH 3 D
- CONFINED MOVES ABOUT 4 D
- CONFINED—DOES NOT MOVE ABOUT 5 D
- DESCRIBE HELP

WALKING
- WITHOUT HELP 0
- MH ONLY 1
- HH ONLY 2
- MH AND HH 3
- DOES NOT WALK 4
- DESCRIBE HELP

WHEELING
- DOES NOT WHEEL-MOVES ABOUT 0
- WITHOUT HELP 1
- MH ONLY 2
- HH ONLY 3
- MH AND HH 4
- IS WHEELED 5
- IS NOT WHEELED 6
- DESCRIBE HELP

STAIRCLIMBING
- WITHOUT HELP 0
- MH ONLY 1
- HH ONLY 2
- MH AND HH 3
- DOES NOT CLIMB 4
- DESCRIBE HELP

COMMUNICATION OF NEEDS
- VERBALLY-ENGLISH 0
- VERBALLY — OTHER LANGUAGE 1
- NONVERBALLY 2
- DOES NOT COMMUNICATE 3
- OTHER LANGUAGE, NONVERBAL COMMUNICATION

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3

FORMAT A AND B

SERVICES CURRENTLY RECEIVED

FILL IN SPACES AS INDICATED

NAME OR NUMBER

THERAPIES
DATE — SPECIFY FREQUENCY
- INHALATION 1 1, 4
- OCCUPATIONAL 1
- PHYSICAL 1
- SPEECH 1
- REALITY/ REMOTIVATION 1
- SOCIAL SERVICE 1
- OTHER 1

OTHER SERVICES/SOCIAL CONTACTS
- RECREATION/ ACTIVITIES 1
- RELIGIOUS SERVICES 1
- VISITORS 1
- OTHER 1

NUTRITION
- DIET—SPECIFY 0, 6
- FOOD/FLUID (of) INTAKE-NO PROB. 0
- PROBLEM— 1 SPECIFY
- SUPPLEMENTAL 1 NOURISHMENTS
- DINING LOCATION 0, 2

SPECIAL NURSING PROCEDURES
SPECIFY SITES WHERE APPLICABLE, TYPE, AND FREQUENCY OF TREATMENT
- DECUBITUS CARE SITE(S) 1, 5 0, 1 1, 7
- DRESSING(S) SITE(S) 1, 5 0, 1
- EYE CARE— 1 SPECIFY
- OXYGEN Rx— 1, 4 TYPE
- RESTORATIVE NURSING BOWEL 1 /BLADDER 2 TRAINING 3 ROM EXERCISES SITES 1, 4 OTHER 1
- RESTRAINTS-SITES OF APPLICATION 1 1, 3
- TEACHING OSTOMY CARE-TYPE 1, 4
- SELF INJECTION OTHER 1 1, 4
- OTHER SPECIAL NURSING 1

PROFESSIONAL VISITS 1, 8 SPECIFY FREQUENCY OF VISITS
- ATTENDING MD/DO
- OTHER MD/DO
- AUDIOLOGIST
- DENTIST
- OPHTHALMOLOGIST/ OPTOMETRIST
- PODIATRIST
- HOME HEALTH
- OTHER

NAME OR NUMBER

MEDICATIONS
SPECIFY EACH MEDICATION BY CATEGORY. INCLUDE DOSE, ROUTE OF ADMINISTRATION 1, 7, FREQUENCY 1, 7 AND TIME OF LAST DOSE AT DISCHARGE. CHECK IF ADMINISTERED UNDER CORRESPONDING DATE.
DATE
- ANALGESICS/ NARCOTICS
- ANTACIDS
- ANTIBIOTICS/ ANTI-INFECTIVES
- ANTICOAGULANTS
- ANTICONVULSIVES
- ANTIHYPER-TENSIVES
- BOWEL REGULATORS
- CARDIAC REGULATORS
- DIURETICS/ ELECTROLYTES
- INSULIN HYPOGLYCEMICS
- SEDATIVES/ BARBITURATES
- TRANQUILIZERS/ ANTIDEPRES-SANTS
- VASODILATORS
- VITAMINS/IRON
- OTHER

MEDICATION ADMINISTRATION
- NO MEDICATIONS 0
- SELF ADM. MONITORED LESS THAN WEEKLY 1
- BY LAY PERSONS, MONITORED LESS THAN WEEKLY 2
- BY LICENSED/PROF. NURSE AND/OR MONITORED WEEKLY OR MORE 3 d
- BY PROFESSIONAL NURSE 4 D

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4

FORMAT A AND B

TRANSLATION TO SERVICE NEEDS

1. RECORD THE DATE OF ASSESSMENT
2. MATCH THE ASSESSED STATUS RECORDED AS d, D, OR DD IN THE COMPLETED ASSESSMENT WITH THE SAME ITEMS IN THE ASSESSED STATUS COLUMN BELOW. CHECK THE SERVICE(S) NEXT TO EACH MATCHED ITEM UNDER THE DATE OF ASSESSMENT
3. MATCH THE ASSESSED STATUS FOR BEHAVIOR PATTERN WITH THAT OF ORIENTATION AND CHECK THE CORRESPONDING SERVICE AS NEEDED. IF THE ASSESSED STATUS IS "1" FOR BEHAVIOR AND ORIENTATION, NO SERVICE IS CHECKED AS NEEDED

NAME OR NUMBER

ADDITIONAL INFORMATION/PLAN

ASSESSED STATUS	DATE / SERVICE NEEDS 1	✓ OR SPECIFY, IF CHANGE OCCURS, RECORD DATE AND CHANGE: SOCIAL SUPPORT 2	SERVICE PROVIDER	AT REASSESSMENT, DATE AND ✓ IF SERVICE RECEIVED 1
NON-INSTITUTIONAL LIVING SPACE D Not Available	HOMEFINDING SERVICE			
SIGHT D IMPAIRMENT — NO (ATTEMPTED) COMPENSATION	OPHTHALMOLOGY/OPTOMETRY			
HEARING D IMPAIRMENT — NO (ATTEMPTED) COMPENSATION	AUDIOLOGY			
SPEECH D IMPAIRMENT SIX MONTHS AGO OR LESS — THERAPY NOT COMPLETED	SPEECH THERAPY			
DENTITION D SOME OR NO OPPOSING TEETH — NO COMPENSATION	DENTAL SERVICE			
FRACTURED HIP(S) DD / PARALYSIS/PARESIS DD — ONE YEAR AGO OR LESS AND REHABILITATION NOT COMPLETED MISSING LIMBS D REHABILITATION NOT COMPLETED JOINT MOTION INSTABILITY UNCORRECTED OR IMMOBILITY D	PHYSICAL THERAPY			
LIMITED MOTION d EATING/FEEDING DD FED BY I.V. OR CLYSIS MEDICATION ADMINISTRATION SOME OR ALL BY PROFESSIONAL NURSE D	PROFESSIONAL NURSING			
BY LICENSED OR PROFESSIONAL NURSE d	LICENSED OR PROFESSIONAL NURSING			
ACTIVITIES OF DAILY LIVING ADL: BATHING, DRESSING, TOILETING, TRANSFERRING — D FOR 5, 6, OR 7 ADL BOWEL FUNCTION, BLADDER FUNCTION, EATING/FEEDING — D FOR 2, 3, 4, 5, 6, OR 7 ADL	MEAL PREPARATION HOUSEKEEPING ADL OR SUPERVISION BY LAY PERSONS OR AIDES			
BEHAVIOR PATTERN / ORIENTATION: 1-APPROPRIATE OR WANDERING/PASSIVE LESS THAN WEEKLY AND d-DISORIENTED SOME SPHERES d-WANDERING/PASSIVE WEEKLY OR MORE AND 1-ORIENTED	ADL OR SUPERVISION BY LAY PERSONS OR AIDES			
1-APPROPRIATE OR WANDERING/PASSIVE LESS THAN WEEKLY AND D-DISORIENTED ALL SPHERES d-WANDERING/PASSIVE WEEKLY OR MORE AND d,D-DISORIENTED SOME OR ALL SPHERES D-ABUSIVE/AGGRESSIVE DISRUPTIVE LESS THAN WEEKLY AND 1, d, OR D ORIENTED OR DISORIENTED	EMOTIONAL AND SOCIAL ASSESSMENT SERVICES			
DD-ABUSIVE/AGGRESSIVE/DISRUPTIVE WEEKLY OR MORE AND 1, d, OR D ORIENTED OR DISORIENTED	EMOTIONAL AND SOCIAL TREATMENT SERVICES			
MOBILITY LEVEL d, D GOES OUTSIDE WITH HELP OR DOES NOT GO OUTSIDE	SHOPPING			
OTHER SERVICE NEEDS				

PREFERENCES ☐ NONE 0

FOOD 1	ACTIVITIES/HOBBIES/INTERESTS 2	OTHER 3

REASON FOR REFERRAL/DISCHARGE

IF DECEASED,[1] CAUSE OF DEATH H-ICDA CODE DATE

PHYSICIAN'S SIGNATURE

PHYSICIAN'S ORDERS FOR CARE

NAME OR NUMBER

PHYSICIAN'S SIGNATURE DATE DATE OF NEXT VISIT

I ( ) CERTIFY ( ) RECERTIFY THAT ( ) SKILLED 1 ( ) INTERMEDIATE 2 NURSING CARE ( ) OTHER PROFESSIONAL 3 SERVICES ARE REQUIRED BY THE BENEFICIARY ( ) ON AN IN-PATIENT BASIS OR ( ) ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME. FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE ( ) MEDICARE 1 ( ) MEDICAID 2 REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY ( ) ME OR ( ) ______ AT LEAST EVERY ______ MONTHS.

PROGNOSIS REHABILITATION POTENTIAL PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S SIGNATURE DATE DATE OF NEXT VISIT

I ( ) CERTIFY ( ) RECERTIFY THAT ( ) SKILLED 1 ( ) INTERMEDIATE 2 NURSING CARE ( ) OTHER PROFESSIONAL 3 SERVICES ARE REQUIRED BY THE BENEFICIARY ( ) ON AN IN-PATIENT BASIS OR ( ) ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME. FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE ( ) MEDICARE 1 ( ) MEDICAID 2 REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY ( ) ME OR ( ) ______ AT LEAST EVERY ______ MONTHS.

PROGNOSIS REHABILITATION POTENTIAL PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S SIGNATURE DATE DATE OF NEXT VISIT

I ( ) CERTIFY ( ) RECERTIFY THAT ( ) SKILLED 1 ( ) INTERMEDIATE 2 NURSING CARE ( ) OTHER PROFESSIONAL 3 SERVICES ARE REQUIRED BY THE BENEFICIARY ( ) ON AN IN-PATIENT BASIS OR ( ) ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME. FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE ( ) MEDICARE 1 ( ) MEDICAID 2 REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY ( ) ME OR ( ) ______ AT LEAST EVERY ______ MONTHS.

PROGNOSIS REHABILITATION POTENTIAL PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S SIGNATURE DATE DATE OF NEXT VISIT

I ( ) CERTIFY ( ) RECERTIFY THAT ( ) SKILLED 1 ( ) INTERMEDIATE 2 NURSING CARE ( ) OTHER PROFESSIONAL 3 SERVICES ARE REQUIRED BY THE BENEFICIARY ( ) ON AN IN-PATIENT BASIS OR ( ) ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME. FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE ( ) MEDICARE 1 ( ) MEDICAID 2 REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY ( ) ME OR ( ) ______ AT LEAST EVERY ______ MONTHS.

PROGNOSIS REHABILITATION POTENTIAL PHYSICIAN'S SIGNATURE DATE

ADDITIONAL COMMENTS/JUSTIFICATIONS/RECOMMENDATIONS/DECISIONS

SIGNATURE	SIGNATURE	SIGNATURE	SIGNATURE
AFFILIATION	AFFILIATION	AFFILIATION	AFFILIATION

* * * * * * * *

Title of Regulation: **State Plan for Medical Assistance Relating to Cost Management Initiatives for PIRS and Occupational/Speech-Language Services.**
VR 460-03-3.1100. Amount, Duration and Scope of Services.
VR 460-03-4.1940:1. Nursing Home Payment System.
VR 460-03-4.1943. Cost Reimbursement Limitations.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until June 7, 1991.
(See Calendar of Events section for additional information)

Summary:

The proposed regulation would make permanent these three provisions currently existing under emergency regulations: the elimination of cost reimbursement to nursing facilities' licensed in-house pharmacies, limitations of the cost of management services, and reimbursement for occupational and speech/language therapies through nursing facility cost reports.

The Plan sections affected by this proposed action are the PIRS nursing facility reimbursement methodology (VR 460-03-4.1940:1) and the Amount, Duration, and Scope of Services, Supplement 1 (VR 460-03-3.1100).

DMAS promulgated all three provisions originally as emergency regulations on August 2, 1990. The provisions affecting limitations on management services and elimination of cost reimbursement for in-house pharmacies were tied to the reimbursement methodology which existed at the time. When that methodology was replaced by the current Patient Intensity Rating System methodology on October 1, 1990, these two provisions once again were promulgated as an emergency regulation on October 31, 1990.

Nursing Facilities' In-house Pharmacies Reimbursement:

This provision eliminates cost reimbursement for pharmacy services provided by nursing facilities that operate licensed in-house pharmacies, and requires licensed in-house pharmacies in nursing facilities to submit bills and receive payment for pharmacy services in the same manner as free-standing pharmacies, under separate provider agreements.

This change provides DMAS with a consistent and fair basis and policy for the reimbursement of pharmacy services provided to Medicaid recipients in all nursing facilities by using the effective computerized claims processing system. The Program continues the policy of requiring personal physician fees to be billed directly to DMAS by the physicians.

Limitations on Management Services Expenses:

This provision provides that the ceiling limitation for the costs of management services is the median per diem cost of all management services claimed by all nursing facilities in Virginia. Management services in excess of this ceiling limitation will not be reimbursed by DMAS. Prior to this amendment, the only constraint on the costs of management services was the total operating cost ceiling. This amendment will assure DMAS that reimbursement will be made only for those management services that are necessary and cost effective.

Therapies Reimbursement through Cost Reports:

This provision eliminates direct payment to enrolled rehabilitation agencies for occupational and speech therapy services provided to Medicaid recipients in nursing homes. Reimbursement for these services is to be continued through cost reports as provided for in the PIRS methodology. Delivery of medically necessary services is not expected to be affected by this policy.

VR 460-03-3.1100. Amount, Duration and Scope of Services.

§ 1. Inpatient hospital services other than those provided in an institution for mental diseases.

A. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under 15 days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed 14 days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection F of this section.)

B. Medicaid does not pay the medicare (Title XVIII) coinsurance for hospital care after 21 days regardless of the length-of-stay covered by the other insurance. (See exception to subsection F of this section.)

C. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus were carried to term.

D. Reimbursement for covered hospital days is limited to one day prior to surgery, unless medically justified. Hospital claims with an admission date more than one day prior to the first surgical date will pend for review by medical staff to determine appropriate medical justification. The hospital must write on or attach the justification to the billing invoice for consideration of

reimbursement for additional preoperative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

E. Reimbursement will not be provided for weekend (Friday/Saturday) admissions, unless medically justified. Hospital claims with admission dates on Friday or Saturday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

F. Coverage of inpatient hospitalization will be limited to a total of 21 days for all admissions within a fixed period, which would begin with the first day inpatient hospital services are furnished to an eligible recipient and end 60 days from the day of the first admission. There may be multiple admissions during this 60-day period; however, when total days exceed 21, all subsequent claims will be reviewed. Claims which exceed 21 days within 60 days with a different diagnosis and medical justification will be paid. Any claim which has the same or similar diagnosis will be denied.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Medical documentation justifying admission and the continued length of stay must be attached to or written on the invoice for review by medical staff to determine medical necessity. Medically unjustified days in such admissions will be denied.

G. Reimbursement will not be provided for inpatient hospitalization for any selected elective surgical procedures that require a second surgical opinion unless a properly executed second surgical opinion form has been obtained from the physician and submitted with the hospital invoice for payment, or is a justified emergency or exemption. The requirements for second surgical opinion do not apply to recipients in the retroactive eligibility period.

H. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the mandatory outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions. The requirements for mandatory outpatient surgery do not apply to recipients in the retroactive eligibility period.

I. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

J. The department may exempt portions or all of the utilization review documentation requirements of subsections A, D, E, F as it pertains to recipients under age 21, G, or H in writing for specific hospitals from time to time as part of their ongoing hospital utilization review performance evaluation. These exemptions are based on utilization review performance and review edit criteria which determine an individual hospital's review status as specified in the hospital provider manual. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterlization, hysterectomy or abortion procedures were performed, shall be subject to medical documentation requirements.

K. Hospitals qualifying for an exemption of all documentation requirements except as described in subsection J above shall be granted "delegated review status" and shall, while the exemption remains in effect, not be required to submit medical documentation to support pended claims on a prepayment hospital utilization review basis to the extent allowed by federal or state law or regulation. The following audit conditions apply to delegated review status for hospitals:

1. The department shall conduct periodic on-site post-payment audits of qualifying hospitals using a statistically valid sampling of paid claims for the purpose of reviewing the medical necessity of inpatient stays.

2. The hospital shall make all medical records of which medical reviews will be necessary available upon request, and shall provide an appropriate place for the department's auditors to conduct such review.

3. The qualifying hospital will immediately refund to the department in accordance with § 32.1-325.1 A and B of the Code of Virginia the full amount of any initial overpayment identified during such audit.

4. The hospital may appeal adverse medical necessity and overpayment decisions pursuant to the current administrative process for appeals of post-payment

review decisions.

5. The department may, at its option, depending on the utilization review performance determined by an audit based on criteria set forth in the hospital provider manual, remove a hospital from delegated review status and reapply certain or all prepayment utilization review documentation requirements.

§ 2. Outpatient hospital and rural health clinic services.

2a. Outpatient hospital services.

1. Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

a. Are furnished to outpatients;

b. Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist; and

c. Are furnished by an institution that:

(1) Is licensed or formally approved as a hospital by an officially designated authority for state standard-setting; and

(2) Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare.

2. Reimbursement for induced abortions is provided in only those cases in which there would be substantial endangerment of health or life to the mother if the fetus were carried to term.

3. Reimbursement will not be provided for outpatient hospital services for any selected elective surgical procedures that require a second surgical opinion unless a properly executed second surgical opinion form has been obtained from the physician and submitted with the invoice for payment, or is a justified emergency or exemption.

2b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

The same service limitations apply to rural health clinics as to all other services.

2c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with § 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

The same service limitations apply to FQHCs as to all other services.

§ 3. Other laboratory and x-ray services.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

§ 4. Skilled nursing facility services, EPSDT and family planning.

4a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Service must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

4b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

1. Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities, and the accompanying attendant physician care, in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination.

2. Routine physicals and immunizations (except as provided through EPSDT) are not covered except that well-child examinations in a private physician's office are covered for foster children of the local social services departments on specific referral from those departments.

3. Orthoptics services shall only be reimbursed if medically necessary to correct a visual defect identified by an EPSDT examination or evaluation. The department shall place appropriate utilization controls upon this service.

4c. Family planning services and supplies for individuals of child-bearing age.

Service must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts.

§ 5. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

A. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function.

B. Cosmetic surgical procedures are not covered unless performed for physiological reasons and require Program

prior approval.

C. Routine physicals and immunizations are not covered except when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and when a well-child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

D. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension (subject to the approval of the Psychiatric Review Board) of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period. These limitations also apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine.

E. Any procedure considered experimental is not covered.

F. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus were carried to term.

G. Physician visits to inpatient hospital patients are limited to a maximum of 21 days per admission within 60 days for the same or similar diagnoses and is further restricted to medically necessary inpatient hospital days as determined by the Program.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical examination. Payments for physician visits for inpatient days determined to be medically unjustified will be adjusted.

H. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine are covered.

I. Reimbursement will not be provided for physician services for those selected elective surgical procedures requiring a second surgical opinion unless a properly executed second surgical opinion form has been submitted with the invoice for payment, or is a justified emergency or exemption. The requirements for second surgical opinion do not apply to recipients in a retroactive eligibility period.

J. Reimbursement will not be provided for physician services performed in the inpatient setting for those surgical or diagnostic procedures listed on the mandatory outpatient surgery list unless the service is medically justified or meets one of the exceptions. The requirements of mandatory outpatient surgery do not apply to recipients in a retroactive eligibility period.

K. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Coverage of transplant services for all eligible persons is limited to transplants for kidneys and corneas. Kidney transplants require preauthorization. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. The amount of reimbursement for covered kidney transplant services is negotiable with the providers on an individual case basis. Reimbursement for covered cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in Attachment 3.1 E.

§ 6. Medical care by other licensed practitioners within the scope of their practice as defined by state law.

A. Podiatrists' services.

1. Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by state law.

2. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

3. The Program may place appropriate limits on a service based on medical necessity or for utilization control, or both.

B. Optometric services.

1. Diagnostic examination and optometric treatment procedures allowed by the Code of Virginia and by regulations of the Boards of Medicine and Optometry, are covered for all recipients. Routine refractions are limited to once in 24 months except as may be authorized by the agency.

C. Chiropractors' services.

Not provided.

D. Other practitioners' services.

1. Clinical psychologists' services.

a. These limitations apply to psychotherapy sessions by clinical psychologists licensed by the State Board of Medicine. Psychiatric services are limited to an initial availability of 26 sessions, with one possible extension of 26 sessions during the first year of treatment. The availability is further restricted to no more than 26 sessions each succeeding year when approved by the Psychiatric Review Board. Psychiatric services are further restricted to no more than three sessions in any given seven-day period.

b. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine are covered.

§ 7. Home health services.

A. Service must be ordered or prescribed and directed or performed within the scope of a license of a practitioner of the healing arts.

B. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

C. Home health aide services provided by a home health agency.

Home health aides must function under the supervision of a professional nurse.

D. Medical supplies, equipment, and appliances suitable for use in the home.

1. All medical supplies, equipment, and appliances are available to patients of the home health agency.

2. Medical supplies, equipment, and appliances for all others are limited to home renal dialysis equipment and supplies, and respiratory equipment and oxygen, and ostomy supplies, as preauthorized by the local health department.

E. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Service covered only as part of a physician's plan of care.

§ 8. Private duty nursing services.

Not provided.

§ 9. Clinic services.

A. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment of health or life to the mother if the fetus was carried to term.

B. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

1. Are provided to outpatients;

2. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. Except in the case of nurse-midwife services, as specified in 42 CFR § 440.165, are furnished by or under the direction of a physician or dentist.

§ 10. Dental services.

A. Dental services are limited to recipients under 21 years of age in fulfillment of the treatment requirements under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and defined as routine diagnostic, preventive, or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

B. Initial, periodic, and emergency examinations; required radiography necessary to develop a treatment plan; patient education; dental prophylaxis; fluoride treatments; dental sealants; routine amalgam and composite restorations; crown recementation; pulpotomies; emergency endodontics for temporary relief of pain; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure are dental services covered without preauthorization by the state agency.

C. All covered dental services not referenced above require preauthorization by the state agency. The following services are also covered through preauthorization: medically necessary full banded orthodontics, for handicapping malocclusions, minor tooth guidance or repositioning appliances, complete and partial dentures, surgical preparation (alveoloplasty) for prosthetics, single permanent crowns, and bridges. The following service is not covered: routine bases under restorations.

D. The state agency may place appropriate limits on a service based on medical necessity, for utilization control, or both. Examples of service limitations are: examinations, prophylaxis, fluoride treatment (once/six months); space maintenance appliances; bitewing x-ray – two films (once/12 months); routine amalgam and composite restorations (once/three years); dentures (once per 5 years); extractions, orthodontics, tooth guidance appliances, permanent crowns, and bridges, endodontics, patient

education and sealants (once).

E. Limited oral surgery procedures, as defined and covered under Title XVIII (Medicare), are covered for all recipients, and also require preauthorization by the state agency.

§ 11. Physical therapy and related services.

11a. Physical therapy.

A. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient service, skilled nursing home service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective July 1, 1988, the Program will not provide direct reimbursement to enrolled providers for physical therapy services rendered to patients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing ~~homes'~~ *home's* operating cost.

11b. Occupational therapy.

A. Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, skilled nursing home service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective August 2, 1990, the Program will not provide direct reimbursement to enrolled providers for occupational therapy rendered to patients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing homes's operating cost.

11c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist; see General section and subsections 11a and 11b of this section).

A. These services are provided by or under the supervision of a speech pathologist or an audiologist only as an element of hospital inpatient or outpatient service, skilled nursing home service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

B. Effective August 2, 1990, the Program will not provide reimbursement to enrolled providers for speech therapy rendered to patients residing in long-term care facilities. Reimbursement for these services is and continues to be included as a component of the nursing home's operating cost.

§ 12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12a. Prescribed drugs.

1. Nonlegend drugs, except insulin, syringes, needles, diabetic test strips for clients under 21 years of age, and family planning supplies are not covered by Medicaid. This limitation does not apply to Medicaid recipients who are in skilled and intermediate care facilities.

2. Legend drugs, with the exception of anorexiant drugs prescribed for weight loss and transdermal drug delivery systems, are covered. Coverage of anorexiants for other than weight loss requires preauthorization.

3. The Program will not provide reimbursement for drugs determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

4. Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, prescriptions for Medicaid recipients for specific multiple source drugs shall be filled with generic drug products listed in the Virginia Voluntary Formulary unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written.

5. New drugs, except for Treatment Investigational New Drugs (Treatment IND), are not covered until approved by the board, unless a physician obtains prior approval. The new drugs listed in Supplement 1 to the New Drug Review Program regulations (VR 460-05-2000.1000) are not covered.

12b. Dentures.

Provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

12c. Prosthetic devices.

A. Prosthetics services shall mean the replacement of missing arms and legs. Nothing in this regulation shall be construed to refer to orthotic services or devices.

B. Prosthetic devices (artificial arms and legs, and their necessary supportive attachments) are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and preauthorized for the minimum applicable component necessary for the activities of daily living.

12d. Eyeglasses.

Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

§ 13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13a. Diagnostic services.

Not provided.

13b. Screening services.

Not provided.

13c. Preventive services.

Not provided.

13d. Rehabilitative services.

1. Medicaid covers intensive inpatient rehabilitation services as defined in § 2.1 in facilities certified as rehabilitation hospitals or rehabilitation units in acute care hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System.

2. Medicaid covers intensive outpatient rehabilitation services as defined in § 2.1 in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs), or when the outpatient program is administered by a rehabilitation hospital or an exempted rehabilitation unit of an acute care hospital certified and participating in Medicaid.

3. These facilities are excluded from the 21-day limit otherwise applicable to inpatient hospital services. Cost reimbursement principles are defined in Attachment 4.19-A.

4. An intensive rehabilitation program provides intensive skilled rehabilitation nursing, physical therapy, occupational therapy, and, if needed, speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation. The nursing staff must support the other disciplines in carrying out the activities of daily living, utilizing correctly the training received in therapy and furnishing other needed nursing services. The day-to-day activities must be carried out under the continuing direct supervision of a physician with special training or experience in the field of rehabilitation.

§ 14. Services for individuals age 65 or older in institutions for mental diseases.

14a. Inpatient hospital services.

Provided, no limitations.

14b. Skilled nursing facility services.

Provided, no limitations.

14c. Intermediate care facility.

Provided, no limitations.

§ 15. Intermediate care services and intermediate care services for institutions for mental disease and mental retardation.

15a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with § 1902 (a)(31)(A) of the Act, to be in need of such care.

Provided, no limitations.

15b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided, no limitations.

§ 16. Inpatient psychiatric facility services for individuals under 22 years of age.

Not provided.

§ 17. Nurse-midwife services.

Covered services for the nurse midwife are defined as those services allowed under the licensure requirements of the state statute and as specified in the Code of Federal Regulations, i.e., maternity cycle.

§ 18. Hospice care (in accordance with § 1905 (o) of the Act).

Not provided.

§ 19. Case management services for high-risk pregnant women and children up to age 1, as defined in Supplement 2 to Attachment 3.1-A in accordance with § 1915(g)(1) of the Act.

§ 20. Extended services to pregnant women.

20a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

The same limitations on all covered services apply to this group as to all other recipient groups.

20b. Services for any other medical conditions that may complicate pregnancy.

The same limitations on all covered services apply to this group as to all other recipient groups.

§ 21. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary of Health and Human Services.

21a. Transportation.

Nonemergency transportation is administered by local health department jurisdictions in accordance with reimbursement procedures established by the Program.

21b. Services of Christian Science nurses.

Not provided.

21c. Care and services provided in Christian Science sanitoria.

Provided, no limitations.

21d. Skilled nursing facility services for patients under 21 years of age.

Provided, no limitations.

21e. Emergency hospital services.

Provided, no limitations.

21f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Not provided.

Emergency Services for Aliens (17.e)

No payment shall be made for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law unless such services are necessary for the treatment of an emergency medical condition of the alien.

Emergency services are defined as:

Emergency treatment of accidental injury or medical condition (including emergency labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical/surgical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Medicaid eligibility and reimbursement is conditional upon review of necessary documentation supporting the need for emergency services. Services and inpatient lengths of stay cannot exceed the limits established for other Medicaid recipients.

Claims for conditions which do not meet emergency critieria for treatment in an emergency room or for acute care hospital admissions for intensity of service or severity of illness will be denied reimbursement by the Department of Medical Assistance Services.

VR 460-03-4.1940:1. Nursing Home Payment System: Patient Intensity Rating System.

PART I.
INTRODUCTION.

§ 1.1. Effective October 1, 1990, the payment methodology for Nursing Facility (NF) reimbursement by the Virginia Department of Medical Assistance Services (DMAS) is set forth in the following document. The formula provides for incentive payments to efficiently operated NFs and contains payment limitations for those NFs operating less efficiently. A cost efficiency incentive encourages cost containment by allowing the provider to retain a percentage of the difference between the prospectively determined operating cost rate and the ceiling.

§ 1.2. Three separate cost components are used: plant cost , operating cost and nurse aide training and competency evaluation program and competency evaluation program (NATCEPs) costs. The rates, which are determined on a facility-by-facility basis, shall be based on annual cost reports filed by each provider.

§ 1.3. In determining the ceiling limitations, there shall be direct patient care medians established for NFs in the Virginia portion of the Washington DC-MD-VA Metropolitan Statistical Area (MSA), the Richmond-Petersburg Metropolitan Statistical Area (MSA), and in the rest of the state. There shall be indirect patient care medians established for NFs in the Virginia portion of the Washington DC-MD-VA MSA, and in the rest of the state. The Washington DC-MD-VA MSA and the Richmond-Petersburg MSA shall include those cities and counties as listed and changed from time to time by the Health Care Financing Administration (HCFA). A NF located in a jurisdiction which HCFA adds to or removes from the Washington DC-MD-VA MSA or the Richmond-Petersburg MSA shall be placed in its new peer group, for purposes of reimbursement, at the beginning of its next fiscal year following the effective date of HCFA's final rule.

§ 1.4. Institutions for mental diseases providing nursing services for individuals age 65 and older shall be exempt from the prospective payment system as defined in §§ 2.6, 2.7, 2.8, 2.19, and 2.25, as are mental retardation facilities. All other sections of this payment system relating to reimbursable cost limitations shall apply. These facilities

shall continue to be reimbursed retrospectively on the basis of reasonable costs in accordance with Medicare and Medicaid principles of reimbursement. Reimbursement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall be limited to the highest rate paid to a state ICF/MR institution, approved each July 1 by DMAS.

§ 1.5. Except as specifically modified herein, Medicare principles of reimbursement, as amended from time to time, shall be used to establish the allowable costs in the rate calculations. Allowable costs must be classified in accordance with the DMAS uniform chart of accounts (see VR 460-03-4.1941, Uniform Expense Classification) and must be identifiable and verified by contemporaneous documentation.

All matters of reimbursement which are part of the DMAS reimbursement system shall supercede Medicare principles of reimbursement. Wherever the DMAS reimbursement system conflicts with Medicare principles of reimbursement, the DMAS reimbursement system shall take precedence. Appendices are a part of the DMAS reimbursement system.

PART II.
RATE DETERMINATION PROCEDURES.

Article 1.
Plant Cost Component.

§ 2.1. Plant cost.

A. Plant cost shall include actual allowable depreciation, interest, rent or lease payments for buildings and equipment as well as property insurance, property taxes and debt financing costs allowable under Medicare principles of reimbursement or as defined herein.

B. To calculate the reimbursement rate, plant cost shall be converted to a per diem amount by dividing it by the greater of actual patient days or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.

C. For NFs of 30 beds or less, to calculate the reimbursement rate, the number of patient days will be computed as not less than 85% of the daily licensed bed complement.

D. Costs related to equipment and portions of a building/facility not available for patient care related activities are nonreimbursable plant costs.

§ 2.2. New nursing facilities and bed additions.

A. 1. Providers shall be required to obtain three competitive bids when (i) constructing a new physical plant or renovating a section of the plant when changing the licensed bed capacity, and (ii) purchasing fixed equipment or major movable equipment related to such projects.

2. All bids must be obtained in an open competitive market manner, and subject to disclosure to DMAS prior to initial rate setting. (Related parties see § 2.10.)

B. Reimbursable costs for building and fixed equipment shall be based upon the 3/4 (25% of the surveyed projects with costs above the median, 75% with costs below the median) square foot costs for NFs published annually in the R.S. Means Building Construction Cost Data as adjusted by the appropriate R.S. Means Square Foot Costs "Location Factor" for Virginia for the locality in which the NF is located. Where the specific location is not listed in the R.S. Means Square Foot Costs "Location Factor" for Virginia, the facility's zip code shall be used to determine the appropriate locality factor from the U.S. Postal Services National Five Digit Zip Code for Virginia and the R.S. Means Square Foot Costs "Location Factors." The provider shall have the option of selecting the construction cost limit which is effective on the date the Certificate of Public Need (COPN) is issued or the date the NF is licensed. Total cost shall be calculated by multiplying the above 3/4 square foot cost by 385 square feet (the average per bed square footage). Total costs for building additions shall be calculated by multiplying the square footage of the project by the applicable components of the construction cost in the R.S. Means Square Foot Costs, not to exceed the total per bed cost for a new NF. Reasonable limits for renovations shall be determined by the appropriate costs in the R.S. Means Repair and Remodeling Cost Data, not to exceed the total R.S. Means Building Construction Cost Data 3/4 square foot costs for nursing homes.

C. New NFs and bed additions to existing NFs must have prior approval under the state's Certificate of Public Need Law and Licensure regulations in order to receive Medicaid reimbursement.

D. However in no case shall allowable reimbursed costs exceed 110% of the amounts approved in the original COPN, or 100% of the amounts approved in the original COPN as modified by any "significant change" COPN, where a provider has satisfied the requirements of the State Department of Health with respect to obtaining prior written approval for a "significant change" to a COPN which has previously been issued.

§ 2.3. Major capital expenditures.

A. Major capital expenditures include, but are not limited to, major renovations (without bed increase), additions, modernization, other renovations, upgrading to new standards, and equipment purchases. Major capital expenditures shall be any capital expenditures costing $100,000 or more each, in aggregate for like items, or in aggregate for a particular project. These include purchases of similar type equipment or like items within a one calendar year period (not necessarily the provider's reporting period).

B. Providers (including related organizations as defined in § 2.10) shall be required to obtain three competitive bids and if applicable, a Certificate of Public Need before initiating any major capital expenditures. All bids must be obtained in an open competitive manner, and subject to disclosure to the DMAS prior to initial rate setting. (Related parties see § 2.10.)

C. Useful life shall be determined by the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (AHA). If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

D. Major capital additions, modernization, renovations, and costs associated with upgrading the NF to new standards shall be subject to cost limitations based upon the applicable components of the construction cost limits determined in accordance with § 2.2 B.

§ 2.4. Financing.

A. The DMAS shall continue its policy to disallow cost increases due to the refinancing of a mortgage debt, except when required by the mortgage holder to finance expansions or renovations. Refinancing shall also be permitted in cases where refinancing would produce a lower interest rate and result in a cost savings. The total net aggregate allowable costs incurred for all cost reporting periods related to the refinancing cannot exceed the total net aggregate costs that would have been allowable had the refinancing not occurred.

B. Interest rate upper limit.

Financing for all NFs and expansions which require a COPN and all renovations and purchases shall be subject to the following limitations:

1. Interest expenses for debt financing which is exempt from federal income taxes shall be limited to:

The average weekly rates for Baa municipal rated bonds as published in Cragie Incorporated Municipal Finance Newsletter as published weekly (Representative reoffering from general obligation bonds), plus one percentage point (100 basis points), during the week in which commitment for construction financing or closing for permanent financing takes place.

2. a. Effective on and after July 1, 1990, the interest rate upper limit for debt financing by NFs that are subject to prospective reimbursement shall be the average of the rate for 10-year and 30-year U.S. Treasury Constant Maturities, as published in the weekly Federal Reserve Statistical Release (H.15), plus two percentage points (200 basis points).

This limit (i) shall apply only to debt financing which is not exempt from federal income tax, and (ii) shall not be available to NF's which are eligible for such tax exempt financing unless and until a NF has demonstrated to the DMAS that the NF failed, in a good faith effort, to obtain any available debt financing which is exempt from federal income tax. For construction financing, the limit shall be determined as of the date on which commitment takes place. For permanent financing, the limit shall be determined as of the date of closing. The limit shall apply to allowable interest expenses during the term of the financing.

b. The new interest rate upper limit shall also apply, effective July 1, 1990, to construction financing committed to or permanent financing closed after December 31, 1986, but before July 1, 1990, which is not exempt from federal income tax. The limit shall be determined as of July 1, 1990, and shall apply to allowable interest expenses for the term of the financing remaining on or after July 1, 1990.

3. Variable interest rate upper limit.

a. The limitation set forth in §§ 2.4 B 1 and 2.4 B 2 shall be applied to debt financing which bears a variable interest rate as follows. The interest rate upper limit shall be determined on the date on which commitment for construction financing or closing for permanent financing takes place, and shall apply to allowable interest expenses during the term of such financing as if a fixed interest rate for the financing period had been obtained. A "fixed rate loan amortization schedule" shall be created for the loan period, using the interest rate cap in effect on the date of commitment for construction financing or date of closing for permanent financing.

b. If the interest rate for any cost reporting period is below the limit determined in subdivision 3 a above, no adjustment will be made to the providers interest expense for that period, and a "carryover credit" to the extent of the amount allowable under the "fixed rate loan amortization schedule" will be created, but not paid. If the interest rate in a future cost reporting period is above the limit determined in subdivision 3 a above, the provider will be paid this "carryover credit" from prior period(s), not to exceed the cumulative carryover credit or his actual cost, whichever is less.

c. The provider shall be responsible for preparing a verifiable and auditable schedule to support cumulative computations of interest claimed under the "carryover credit," and shall submit such a schedule with each cost report.

4. The limitation set forth in § 2.4 B 1, 2, and 3 shall be applicable to financing for land, buildings, fixed equipment, major movable equipment, working capital for construction and permanent financing.

5. Where bond issues are used as a source of financing, the date of sale shall be considered as the date of closing.

6. The aggregate of the following costs shall be limited to 5.0% of the total allowable project costs:

a. Examination Fees

b. Guarantee Fees

c. Financing Expenses (service fees, placement fees, feasibility studies, etc.)

d. Underwriters Discounts

e. Loan Points

7. The aggregate of the following financing costs shall be limited to 2.0% of the total allowable project costs:

a. Legal Fees

b. Cost Certification Fees

c. Title and Recording Costs

d. Printing and Engraving Costs

e. Rating Agency Fees

C. DMAS shall allow costs associated with mortgage life insurance premiums in accordance with § 2130 of the HCFA-Pub. 15, Provider Reimbursement Manual (PRM-15).

D. Interest expense on a debt service reserve fund is an allowable expense if required by the terms of the financing agreement. However, interest income resulting from such fund shall be used by DMAS to offset interest expense.

§ 2.5. Purchases of nursing facilities (NF).

A. In the event of a sale of a NF, the purchaser must have a current license and certification to receive DMAS reimbursement as a provider.

B. The following reimbursement principles shall apply to the purchase of a NF:

1. The allowable cost of a bona fide sale of a facility (whether or not the parties to the sale were, are, or will be providers of Medicaid services) shall be the lowest of the sales price, the replacement cost value determined by independent appraisal, or the limitations of Part XVI - Revaluation of Assets. Revaluation of assets shall be permitted only when a bona fide sale of assets occurs.

2. Notwithstanding the provisions of § 2.10, where there is a sale between related parties (whether or not they were, are or will be providers of Medicaid services), the buyer's allowable cost basis for the nursing facility shall be the seller's allowable depreciated historical cost (net book value), as determined for Medicaid reimbursement.

3. For purposes of Medicaid reimbursement, a "bona fide" sale shall mean a transfer of title and possession for consideration between parties which are not related. Parties shall be deemed to be "related" if they are related by reasons of common ownership or control. If the parties are members of an immediate family, the sale shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control." See § 2.10 C for definitions of "common ownership," "control," "immediate family," and "significant ownership or control."

4. The useful life of the fixed assets of the facility shall be determined by AHA guidelines.

5. The buyer's basis in the purchased assets shall be reduced by the value of the depreciation recapture due the state by the provider-seller, until arrangements for repayment have been agreed upon by DMAS.

6. In the event the NF is owned by the seller for less than five years, the reimbursable cost basis of the purchased NF to the buyer, shall be the seller's allowable historical cost as determined by DMAS.

C. An appraisal expert shall be defined as an individual or a firm that is experienced and specializes in multi-purpose appraisals of plant assets involving the establishing or reconstructing of the historical cost of such assets. Such an appraisal expert employs a specially trained and supervised staff with a complete range of appraisal and cost construction techniques; is experienced in appraisals of plant assets used by providers, and demonstrates a knowledge and understanding of the regulations involving applicable reimbursement principles, particularly those pertinent to depreciation; and is unrelated to either the buyer or seller.

D. At a minimum, appraisals must include a breakdown by cost category as follows:

1. Building; fixed equipment; movable equipment; land; land improvements.

2. The estimated useful life computed in accordance with AHA guidelines of the three categories, building, fixed equipment, and movable equipment must be included in the appraisal. This information shall be utilized to compute depreciation schedules.

E. Depreciation recapture.

1. The provider-seller of the facility shall make a retrospective settlement with DMAS in instances where a gain was made on disposition. The department shall recapture the depreciation paid to the provider by Medicaid for the period of participation in the Program to the extent there is gain realized on the sale of the depreciable assets. A final cost report and refund of depreciation expense, where applicable, shall be due within 30 days from the transfer of title (as defined below).

2. No depreciation adjustment shall be made in the event of a loss or abandonment.

F. Reimbursable depreciation.

1. For the purpose of this section, "sale or transfer" shall mean any agreement between the transferor and the transferee by which the former, in consideration of the payment or promise of payment of a certain price in money, transfers to the latter the title and possession of the property.

2. Upon the sale or transfer of the real and tangible personal property comprising a licensed nursing facility certified to provide services to DMAS, the transferor or other person liable therein shall reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing such services and subject to recapture under the provisions of the State Plan for Medical Assistance. The amount of reimbursable depreciation shall be paid to the Commonwealth within 30 days of the sale or transfer of the real property unless an alternative form of repayment, the term of which shall not exceed one year, is approved by the director.

3. Prior to the transfer, the transferor shall file a written request by certified or registered mail to the director for a letter of verification that he either does not owe the Commonwealth any amount for reimbursable depreciation or that he has repaid any amount owed the Commonwealth for reimbursable depreciation or that an alternative form of repayment has been approved by the director. The request for a letter of verification shall state:

a. That a sale or transfer is about to be made;

b. The location and general description of the property to be sold or transferred;

c. The names and addresses of the transferee and transferor and all such business names and addresses of the transferor for the last three years; and

d. Whether or not there is a debt owing to the Commonwealth for the amount of depreciation charges previously allowed and reimbursed as a reasonable cost to the transferor under the Virginia Medical Assistance Program.

4. Within 90 days after receipt of the request, the director shall determine whether or not there is an amount due to the Commonwealth by the nursing facility by reason of depreciation charges previously allowed and reimbursed as a reasonable cost under DMAS and shall notify the transferor of such sum, if any.

5. The transferor shall provide a copy of this section and a copy of his request for a letter of verification to the prospective transferee via certified mail at least 30 days prior to the transfer. However, whether or not the transferor provides a copy of this section and his request for verification to the prospective transferee as required herein, the transferee shall be deemed to be notified of the requirements of this law.

6. After the transferor has made arrangements satisfactory to the director to repay the amount due or if there is no amount due, the director shall issue a letter of verification to the transferor in recordable form stating that the transferor has complied with the provisions of this section and setting forth the term of any alternative repayment agreement. The failure of the transferor to reimburse to the Commonwealth the amount of depreciation previously allowed as a reasonable cost of providing service to DMAS in a timely manner renders the transfer of the nursing facility ineffective as to the Commonwealth.

7. Upon a finding by the director that such sale or transfer is ineffective as to the Commonwealth, DMAS may collect any sum owing by any means available by law, including devising a schedule for reducing the Medicaid reimbursement to the transferee up to the amount owed the Commonwealth for reimbursable depreciation by the transferor or other person liable therein. Medicaid reimbursement to the transferee shall continue to be so reduced until repayment is made in full or the terms of the repayment are agreed to by the transferor or person liable therein.

8. In the event the transferor or other person liable therein defaults on any such repayment agreement the reductions of Medicaid reimbursement to the transferee may resume.

An action brought or initiated to reduce the transferee's Medicaid reimbursement or an action for attachment or levy shall not be brought or initiated more than six months after the date on which the sale or transfer has taken place unless the sale or transfer has been concealed or a letter of verification has not been obtained by the transferor or the transferor defaults on a repayment agreement approved by the director.

Article 2.

Operating Cost Component.

§ 2.6. Operating cost.

A. Operating cost shall be the total allowable inpatient cost less plant cost and NATCEPs costs. See Part VII for rate determination procedures for NATCEPs costs. To calculate the reimbursement rate, operating cost shall be converted to a per diem amount by dividing it by the greater of actual patient days, or the number of patient days computed as 95% of the daily licensed bed complement during the applicable cost reporting period.

B. For NFs of 30 beds or less, to calculate the reimbursement rate the number of patient days will continue to be computed as not less than 85% of the daily licensed bed complement.

§ 2.7. Nursing facility reimbursement formula.

A. Effective on and after October 1, 1990, all NFs subject to the prospective payment system shall be reimbursed under a revised formula entitled "The Patient Intensity Rating System (PIRS)." PIRS is a patient based methodology which links NF's per diem rates to the intensity of services required by a NF's patient mix. Three classes were developed which group patients together based on similar functional characteristics and service needs.

1. Any NF receiving Medicaid payments on or after October 1, 1990, shall satisfy all the requirements of § 1919(b) through (d) of the Social Security Act as they relate to provision of services, residents' rights and administration and other matters.

2. In accordance with § 1.3, direct patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA, the Richmond-Petersburg MSA and the rest of the state. Direct patient care operating costs shall be as defined in VR 460-03-1491. Indirect patient care operating cost peer groups shall be established for the Virginia portion of the Washington DC-MD-VA MSA and for the rest of the state. Indirect patient care operating costs shall include all other operating costs, not defined in VR 460-03-4.1941 as direct patient care operating costs and NATCEPs costs.

3. Each NF's Service Intensity Index (SII) shall be calculated for each semiannual period of a NF's fiscal year based upon data reported by that NF and entered into DMAS' Long Term Care Information System (LTCIS). Data will be reported on the multidimensional assessment form prescribed by DMAS (now DMAS-95) at the time of admission and then twice a year for every Medicaid recipient in a NF. The NF's SII, derived from the assessment data, will be normalized by dividing it by the average for all NF's in the state.

See VR 460-03-4.1944 for the PIRS class structure, the relative resource cost assigned to each class, the method of computing each NF's facility score and the methodology of computing the NF's semiannual SIIs.

4. The normalized SII shall be used to calculate the initial direct patient care operating cost peer group medians. It shall also be used to calculate the direct patient care operating cost prospective ceilings and direct patient care operating cost prospective rates for each semiannual period of a NF's subsequent fiscal years.

a. The normalized SII, as determined during the quarter ended September 30, 1990, shall be used to calculate the initial direct patient care operating cost peer group medians.

b. A NF's direct patient care operating cost prospective ceiling shall be the product of the NF's peer group direct patient care ceiling and the NF's normalized SII for the previous semiannual period. A NF's direct patient care operating cost prospective ceiling will be calculated semiannually.

An SSI rate adjustment, if any, shall be applied to a NF's prospective direct patient care operating cost base rate for each semiannual period of a NF's fiscal year. The SII determined in the second semiannual period of the previous fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the first semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate. The SII determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's SIIs to determine the SII rate adjustment, if any, to the second semiannual period of the subsequent fiscal year's prospective direct patient care operating cost base rate.

d. See VR 460-03-4.1944 for an illustration of how the SII is used to adjust direct patient care operating ceilings and the semiannual rate adjustments to the prospective direct patient care operating cost base rate.

5. An adjustment factor shall be applied to both the direct patient care and indirect patient care peer group medians to determine the appropriate initial peer group ceilings.

a. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during fiscal year 1991 under the prospective payment system in effect through September 30, 1990, as modified to incorporate the estimated additional NF reimbursement mandated by the provisions of § 1902(a)(13)(A) of the Social Security Act as amended by § 4211(b)(1) of the

Omnibus Budget Reconciliation Act of 1987.

b. The DMAS shall calculate the estimated gross NF reimbursement required for the forecasted number of NF bed days during FY 1991 under the PIRS prospective payment system.

c. The DMAS shall determine the differential between a and b above and shall adjust the peer group medians within the PIRS as appropriate to reduce the differential to zero.

d. The adjusted PIRS peer group medians shall become the initial peer group ceilings.

B. The allowance for inflation shall be based on the percentage of change in the moving average of the Skilled Nursing Facility Market basket of Routine Service Costs, as developed by Data Resources, Incorporated, adjusted for Virginia, determined in the quarter in which the NF's most recent fiscal year ended. NFs shall have their prospective operating cost ceilings and prospective operating cost rates established in accordance with the following methodology:

1. The initial peer group ceilings established under § 2.7 A shall be the final peer group ceilings for a NF's first full or partial fiscal year under PIRS and shall be considered as the initial "interim ceilings" for calculating the subsequent fiscal year's peer group ceilings. Peer group ceilings for subsequent fiscal years shall be calculated by adjusting the most recent "interim" ceilings for 100% of historical inflation, from the effective date of such "interim" ceilings to the beginning of the NF's next fiscal year to obtain new "interim" ceilings, and 50% of the forecasted inflation to the end of the NF's next fiscal year.

2. A NF's average allowable operating cost rates, as determined from its most recent fiscal year's cost report, shall be adjusted by 50% of historical inflation and 50% of the forecasted inflation to calculate its prospective operating cost base rates.

C. The PIRS method shall still require comparison of the prospective operating cost rates to the prospective operating ceilings. The provider shall be reimbursed the lower of the prospective operating cost rates or prospective operating ceilings.

D. Nonoperating costs.

1. Allowable plant costs shall be reimbursed in accordance with Part II, Article 1. Plant costs shall not include the component of cost related to making or producing a supply or service.

2. NATCEPs cost shall be reimbursed in accordance with Part VII.

E. The prospective rate for each NF shall be based upon operating cost and plant cost components or charges, whichever is lower, plus NATCEPs costs. The disallowance of nonreimbursable operating costs in any current fiscal year shall be reflected in a subsequent year's prospective rate determination. Disallowances of nonreimbursable plant costs and NATCEPs costs shall be reflected in the year in which the nonreimbursable costs are included.

F. For those NFs whose operating cost rates are below the ceilings, an incentive plan shall be established whereby a NF shall be paid, on a sliding scale, up to 25% of the difference between its allowable operating cost rates and the peer group ceilings under the PIRS.

1. The table below presents four incentive examples under the PIRS:

Peer Group Ceilings	Allowable Cost Per Day		Difference % of Ceiling	Sliding Scale	Scale % Difference
$30.00	$27.00	$3.00	10%	$ .30	10%
30.00	22.50	7.50	25%	1.88	25%
30.00	20.00	10.00	33%	2.50	25%
30.00	30.00	0		0	

2. Separate efficiency incentives shall be calculated for both the direct and indirect patient care operating ceilings and costs.

G. Quality of care requirement.

A cost efficiency incentive shall not be paid to a NF for the prorated period of time that it is not in conformance with substantive, nonwaived life, safety, or quality of care standards.

H. Sale of facility.

In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

I. Public notice.

To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

§ 2.8. Phase-in period.

A. To assist NFs in converting to the PIRS methodology, a phase-in period shall be provided until June 30, 1992.

B. From October 1, 1990, through June 30, 1991, a NF's prospective operating cost rate shall be a blended rate calculated at 33% of the PIRS operating cost rates determined by § 2.7 above and 67% of the "current" operating rate determined by subsection D below.

C. From July 1, 1991, through June 30, 1992, a NF's prospective operating cost rate shall be a blended rate calculated at 67% of the PIRS operating cost rates determined by § 2.7 above and 33% of the "current" operating rate determined by subsection D below.

D. The following methodology shall be applied to calculate a NF's "current" operating rate:

1. Each NF shall receive as its base "current" operating rate, the weighted average prospective operating cost per diems and efficiency incentive per diems if applicable, calculated by DMAS to be effective September 30, 1990.

2. The base "current" operating rate established above shall be the "current" operating rate for the NF's first partial fiscal year under PIRS. The base "current" operating rate shall be adjusted by appropriate allowance for historical inflation and 50% of the forecasted inflation based on the methodology contained in § 2.7 B at the beginning of each of the NF's fiscal years which starts during the phase-in period, October 1, 1990, through June 30, 1992, to determine the NF's prospective "current" operating rate. See VR 460-03-4.1944 for example calculations.

Article 3.
Allowable Cost Identification.

§ 2.9. Allowable costs.

Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see VR 460-03-4.1941, Uniform Expense Classification).

A. Certification.

The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.

B. Operating costs.

1. Direct patient care operating costs shall be defined in VR 460-03-4.1941.

2. ~~Excluded from allowable direct patient care operating costs shall be personal physician fees and prescribed legend and nonlegend drugs. These excluded services shall be billed directly to DMAS by the provider of these services.~~ *Allowable direct patient care operating costs shall exclude (i) personal physician fees, and (ii) pharmacy services and prescribed legend and nonlegend drugs provided by nursing facilities which operate licensed in-house pharmacies. These services shall be billed directly to DMAS through separate provider agreements and DMAS shall pay directly in accordance with subsections e and f of Attachment 4.19 B of the State Plan for Medical Assistance (VR 460-02-4.1920).*

3. Indirect patient care operating costs include all other operating costs, not identified as direct patient care operating costs and NATCEPs costs in VR 460-03-4.1941, which are allowable under the Medicare principles of reimbursement, except as specifically modified herein and as may be subject to individual cost or ceiling limitations.

C. Allowances/goodwill.

Bad debts, goodwill, charity, courtesy, and all other contractual allowances shall not be recognized as an allowable cost.

§ 2.10. Purchases/related organizations.

A. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization, provided that such costs do not exceed the price of comparable services, facilities or supplies. Purchases of existing NFs by related parties shall be governed by the provisions of § 2.5 B 2.

Allowable cost applicable to management services furnished to the provider by organizations related to the provider by common ownership or control shall be lesser of the cost to the related organization or the per patient day ceiling limitation established for management services cost. (See VR 460-03-4.1943, Cost Reimbursement Limitations.)

B. Related to the provider shall mean that the provider is related by reasons of common ownership or control by the organization furnishing the services, facilities, or supplies.

C. Common ownership exists when an individual or individuals or entity or entities possess significant ownership or equity in the parties to the transaction. Control exists where an individual or individuals or entity or entities have the power, directly or indirectly, significantly to influence or direct the actions or policies of the parties to the transaction. Significant ownership or control shall be deemed to exist where an individual is a "person with an ownership or control interest" within the meaning of 42 CFR 455.101. If the parties to the transaction are members of an immediate family, as defined below, the transaction shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control,"

as set forth above. Immediate family shall be defined to include, but not be limited to, the following: (i) husband and wife, (ii) natural parent, child and sibling, (iii) adopted child and adoptive parent, (iv) step-parent, step-child, step-sister, and step-brother, (v) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law, and (vi) grandparent and grandchild.

D. Exception to the related organization principle.

1. Effective with cost reports having fiscal years beginning on or after July 1, 1986, an exception to the related organization principle shall be allowed. Under this exception, charges by a related organization to a provider for goods or services shall be allowable cost to the provider if all four of the conditions set out below are met.

2. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of DMAS that the following criteria have been met:

a. The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the provider organization.

b. A substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of goods or services furnished by the organization. In determining whether the activities are of similar type, it is important to also consider the scope of the activity.

For example, a full service management contract would not be considered the same type of business activity as a minor data processing contract. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arms-length bargaining by well informed buyers and sellers.

c. The goods or services shall be those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions. This requirement means that institutions such as the provider typically obtain the good or services from outside sources rather than producing the item internally.

d. The charge to the provider is in line with the charge for such services, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such goods or services. The phrase "open market" takes the same meaning as "open, competitive market" in subdivision b above.

3. Where all of the conditions of this exception are met, the charges by the supplier to the provider for such goods or services shall be allowable as costs.

4. This exception does not apply to the purchase, lease or construction of assets such as property, buildings, fixed equipment or major movable equipment. The terms "goods and services" may not be interpreted or construed to mean capital costs associated with such purchases, leases, or construction.

E. Three competitive bids shall not be required for the building and fixed equipment components of a construction project outlined in § 2.2. Reimbursement shall be in accordance with § 2.10 A with the limitations stated in § 2.2 B.

§ 2.11. Administrator/owner compensation.

A. Administrators' compensation, whether administrators are owners or non-owners, shall be based on a schedule adopted by DMAS and varied according to facility bed size. The compensation schedule shall be adjusted annually to reflect cost-of-living increases and shall be published and distributed to providers annually. The administrator's compensation schedule covers only the position of administrator and assistants and does not include the compensation of owners employed in capacities other than the NF administrator (see VR 460-03-4.1943, Cost Reimbursement Limitations).

B. Administrator compensation shall mean remuneration paid regardless of the form in which it is paid. This includes, but shall not be limited to, salaries, professional fees, insurance premiums (if the benefits accrue to the employer/owner or his beneficiary) director fees, personal use of automobiles, consultant fees, management fees, travel allowances, relocation expenses in excess of IRS guidelines, meal allowances, bonuses, pension plan costs, and deferred compensation plans. Management fees, consulting fees, and other services performed by owners shall be included in the total compensation if they are performing administrative duties regardless of how such services may be classified by the provider.

C. Compensation for all administrators (owner and nonowner) shall be based upon a 40 hour week to determine reasonableness of compensation.

D. Owner/administrator employment documentation.

1. Owners who perform services for a NF as an administrator and also perform additional duties must maintain adequate documentation to show that the additional duties were performed beyond the normal 40 hour week as an administrator. The additional duties must be necessary for the operation of the NF

and related to patient care.

2. Services provided by owners, whether in employee capacity, through management contracts, or through home office relationships shall be compared to the cost and services provided in arms-length transactions.

3. Compensation for such services shall be adjusted where such compensation exceeds that paid in such arms-length transaction or where there is a duplication of duties normally rendered by an administrator. No reimbursement shall be allowed for compensation where owner services cannot be documented and audited.

§ 2.12. Depreciation.

The allowance for depreciation shall be restricted to the straight line method with a useful life in compliance with AHA guidelines. If the item is not included in the AHA guidelines, reasonableness shall be applied to determine useful life.

§ 2.13. Rent/Leases.

Rent or lease expenses shall be limited by the provisions of VR 460-03-4.1942, Leasing of Facilities.

§ 2.14. Provider payments.

A. Limitations.

1. Payments to providers, shall not exceed charges for covered services except for (i) public providers furnishing services free of charge or at a nominal charge (ii) nonpublic provider whose charges are 60% or less of the allowable reimbursement represented by the charges and that demonstrates its charges are less than allowable reimbursement because its customary practice is to charge patients based on their ability to pay. Nominal charge shall be defined as total charges that are 60% or less of the allowable reimbursement of services represented by these charges. Providers qualifying in this section shall receive allowable reimbursement as determined in this Plan.

2. Allowable reimbursement in excess of charges may be carried forward for payment in the two succeeding cost reporting periods. A new provider may carry forward unreimbursed allowable reimbursement in the five succeeding cost reporting periods.

3. Providers may be reimbursed the carry forward to a succeeding cost reporting period (i) if total charges for the services provided in that subsequent period exceed the total allowable reimbursement in that period (ii) to the extent that the accumulation of the carry forward and the allowable reimbursement in that subsequent period do not exceed the providers' direct and indirect care operating ceilings plus allowable plant cost.

B. Payment for service shall be based upon the rate in effect when the service was rendered.

C. An interim settlement shall be made by DMAS within 90 days after receipt and review of the cost report. The word "review," for purposes of interim settlement, shall include verification that all financial and other data specifically requested by DMAS is submitted with the cost report. Review shall also mean examination of the cost report and other required submission for obvious errors, inconsistency, inclusion of past disallowed costs, unresolved prior year cost adjustments and a complete signed cost report that conforms to the current DMAS requirements herein.

However, an interim settlement shall not be made when one of the following conditions exists.

1. Cost report filed by a terminated provider;

2. Insolvency of the provider at the time the cost report is submitted;

3. Lack of a valid provider agreement and decertification;

4. Moneys owed to DMAS;

5. Errors or inconsistencies in the cost report; or

6. Incomplete/nonacceptable cost report.

§ 2.15. Legal fees/accounting.

A. Costs claimed for legal/accounting fees shall be limited to reasonable and customary fees for specific services rendered. Such costs must be related to patient care as defined by Medicare principles of reimbursement and subject to applicable regulations herein. Documentation for legal costs must be available at the time of audit.

B. Retainer fees shall be considered an allowable cost up to the limits established in VR 460-03-4.1943, Cost Reimbursement Limitations.

§ 2.16. Documentation.

Adequate documentation supporting cost claims must be provided at the time of interim settlement, cost settlement, audit, and final settlement.

§ 2.17. Fraud and abuse.

Previously disallowed costs which are under appeal and affect more than one cost reporting period shall be disclosed in subsequent cost reports if the provider wishes to reserve appeal rights for such subsequent cost reports. The reimbursement effect of such appealed costs shall be computed by the provider and submitted to DMAS with the cost report. Where such disclosure is not made to

DMAS, the inclusion of previously disallowed costs may be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General.

Article 4.
New Nursing Facilities.

§ 2.18. Interim rate.

A. For all new or expanded NFs the 95% occupancy requirement shall be waived for establishing the first cost reporting period interim rate. This first cost reporting period shall not exceed 12 months from the date of the NF's certification.

B. Upon a showing of good cause, and approval of the DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate, or being treated as a new NF.

C. The 95% occupancy requirement shall be applied to the first and subsequent cost reporting periods' actual costs for establishing such NF's second and future cost reporting periods' prospective reimbursement rates. The 95% occupancy requirement shall be considered as having been satisfied if the new NF achieved a 95% occupancy at any point in time during the first cost reporting period.

D. A new NF's interim rate for the first cost reporting period shall be determined based upon the lower of its anticipated allowable cost determined from a detailed budget (or pro forma cost report) prepared by the provider and accepted by the DMAS, or the appropriate operating ceilings or charges.

E. Any NF receiving reimbursement under new NF status shall not be eligible to receive the blended phase-in period rate under § 2.8.

F. During its first semiannual period of operation, a newly constructed or newly enrolled NF shall have an assigned SII based upon its peer group's average SII for direct patient care. An expanded NF receiving new NF treatment, shall receive the SII calculated for its last semiannual period prior to obtaining new NF status.

§ 2.19. Final rate.

The DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined above in § 2.18 A, C, E, and F.

Upon determination of the actual allowable operating cost for direct patient care and indirect patient care the per diem amounts shall be used to determine if the provider is below the peer group ceiling used to set its interim rate. If costs are below those ceilings, an efficiency incentive shall be paid at settlement of the first year cost report.

This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable operating cost and the peer group ceiling used to set the interim rate. (Refer to § 2.7 F.)

Article 5.
Cost Reports.

§ 2.20. Cost report submission.

A. Cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, it is considered delinquent. The cost report shall be deemed complete when DMAS has received all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows. Multi-facility providers not having individual facility financial statements shall submit the "G" series schedules from the cost report plus a statement of changes in cash flow and corporate consolidated financial statements;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

B. When cost reports are delinquent, the provider's interim rate shall be reduced by 20% the first month and an additional 20% of the original interim rate for each subsequent month the report has not been submitted. DMAS shall notify the provider of the schedule of reductions which shall start on the first day of the following month. For example, for a September 30 fiscal year end, notification will be mailed in early January stating that payments will be reduced starting with the first payment in February.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

§ 2.21. Reporting form.

All cost reports shall be submitted on uniform reporting forms provided by the DMAS, or by Medicare if applicable. Such cost reports, subsequent to the initial cost report period, shall cover a 12-month period. Any exceptions must be approved by the DMAS.

§ 2.22. Accounting method.

The accrual method of accounting and cost reporting is mandated for all providers.

§ 2.23. Cost report extensions.

A. Extension for submission of a cost report may be granted if the provider can document extraordinary circumstances beyond its control.

B. Extraordinary circumstances do not include:

1. Absence or changes of chief finance officer, controller or bookkeeper;

2. Financial statements not completed;

3. Office or building renovations;

4. Home office cost report not completed;

5. Change of stock ownership;

6. Change of intermediary;

7. Conversion to computer; or

8. Use of reimbursement specialist.

§ 2.24. Fiscal year changes.

All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year.

Article 6.
Prospective Rates.

§ 2.25. Time frames.

A. A prospective rate shall be determined by DMAS within 90 days of the receipt of a complete cost report. (See § 2.20 A.) Rate adjustments shall be made retroactive to the first day of the provider's new cost reporting year. Where a field audit is necessary to set a prospective rate, the DMAS shall have an additional 90 days to determine any appropriate adjustments to the prospective rate as a result of such field audit. This time period shall be extended if delays are attributed to the provider.

B. Subsequent to establishing the prospective rate DMAS shall conclude the desk audit of a providers' cost report and determine if further field audit activity is necessary. The DMAS will seek repayment or make retroactive settlements when audit adjustments are made to costs claimed for reimbursement.

Article 7.
Retrospective rates.

§ 2.26. The retrospective method of reimbursement shall be used for Mental Health/Mental Retardation facilities.

§ 2.27. (reserved)

Article 8.
Record Retention.

§ 2.28. Time frames.

A. All of the NF's accounting and related records, including the general ledger, books of original entry, and statistical data must be maintained for a minimum of five years, or until all affected cost reports are final settled.

B. Certain information must be maintained for the duration of the provider's participation in the DMAS and until such time as all cost reports are settled. Examples of such information are set forth in § 2.29.

§ 2.29. Types of records to be maintained.

Information which must be maintained for the duration of the provider's participation in the DMAS includes, but is not limited to:

1. Real and tangible property records, including leases and the underlying cost of ownership;

2. Itemized depreciation schedules;

3. Mortgage documents, loan agreements, and amortization schedules;

4. Copies of all cost reports filed with the DMAS together with supporting financial statements.

§ 2.30. Record availability.

The records must be available for audits by DMAS staff. Where such records are not available, costs shall be disallowed.

Article 9.
Audits.

§ 2.31. Audit overview.

Desk audits shall be performed to verify the completeness and accuracy of the cost report, and reasonableness of costs claimed for reimbursement. Field audits, as determined necessary by the DMAS, shall be performed on the records of each participating provider to determine that costs included for reimbursment were

accurately determined and reasonable, and do not exceed the ceilings or other reimbursement limitations established by the DMAS.

§ 2.32. Scope of audit.

The scope of the audit includes, but shall not be limited to: trial balance verification, analysis of fixed assets, indebtedness, selected revenues, leases and the underlying cost of ownership, rentals and other contractual obligations, and costs to related organizations. The audit scope may also include various other analyses and studies relating to issues and questions unique to the NF and identified by the DMAS. Census and related statistics, patient trust funds, and billing procedures are also subject to audit.

§ 2.33. Field audit requirements.

Field audits shall be required as follows:

1. For the first cost report on all new NF's.

2. For the first cost report in which costs for bed additions or other expansions are included.

3. When a NF is sold, purchased, or leased.

4. As determined by DMAS desk audit.

§ 2.34. Provider notification.

The provider shall be notified in writing of all adjustments to be made to a cost report resulting from desk or field audit with stated reasons and references to the appropriate principles of reimbursement or other appropriate regulatory cites.

§ 2.35. Field audit exit conference.

A. The provider shall be offered an exit conference to be executed within 15 days following completion of the on-site audit activities, unless other time frames are mutually agreed to by the DMAS and provider. Where two or more providers are part of a chain organization or under common ownership, DMAS shall have up to 90 days after completion of all related on-site audit activities to offer an exit conference for all such NFs. The exit conference shall be conducted at the site of the audit or at a location mutually agreeable to the DMAS and the provider.

B. The purpose of the exit conference shall be to enable the DMAS auditor to discuss such matters as the auditor deems necessary, to review the proposed field audit adjustments, and to present supportive references. The provider will be given an opportunity during the exit conference to present additional documentation and agreement or disagreement with the audit adjustments.

C. All remaining adjustments, including those for which additional documentation is insufficient or not accepted by the DMAS, shall be applied to the applicable cost report(s) regardless of the provider's approval or disapproval.

D. The provider shall sign an exit conference form that acknowledges the review of proposed adjustments.

E. After the exit conference the DMAS shall perform a review of all remaining field audit adjustments. Within a reasonable time and after all documents have been submitted by the provider, the DMAS shall transmit in writing to the provider a final field audit adjustment report (FAAR), which will include all remaining adjustments not resolved during the exit conference. The provider shall have 15 days from the date of the letter which transmits the FAAR, to submit any additional documentation which may affect adjustments in the FAAR.

§ 2.36. Audit delay.

In the event the provider delays or refuses to permit an audit to occur or to continue or otherwise interferes with the audit process, payments to the provider shall be reduced as stated in § 2.20 B.

§ 2.37. Field audit time frames.

A. If a field audit is necessary after receipt of a complete cost report, such audit shall be initiated within three years following the date of the last notification of program reimbursement and the on site activities, including exit conferences, shall be concluded within 180 days from the date the field audit begins. Where audits are performed on cost reports for multiple years or providers, the time frames shall be reasonably extended for the benefit of the DMAS and subject to the provisions of § 2.35.

B. Documented delays on the part of the provider will automatically extend the above time frames to the extent of the time delayed.

C. Extensions of the time frames shall be granted to the department for good cause shown.

D. Disputes relating to the timeliness established in §§ 2.35 and 2.37, or to the grant of extensions to the DMAS, shall be resolved by application to the Director of the DMAS or his designee.

PART III.
APPEALS.

§ 3.1. General.

A. NF's have the right to appeal the DMAS's interpretation and application of state and federal Medicaid and applicable Medicare principles of reimbursement in accordance with the Administrative Process Act, § 9-6.14.1 et seq. and § 32.1-325.1 of the Code of Virginia.

B. Nonappealable issues.

1. The use of state and federal Medicaid and applicable Medicare principles of reimbursement.

2. The organization of participating NF's into peer groups according to location as a proxy for cost variation across facilities with similar operating characteristics. The use of individual ceilings as a proxy for determining efficient operation within each peer group.

3. Calculation of the initial peer group ceilings using the most recent cost settled data available to DMAS that reflects NF operating costs inflated to September 30, 1990.

4. The use of the moving average of the Skilled Nursing Facility market basket of routine service costs, as developed by Data Resources, Incorporated, adjusted for Virginia, as the prospective escalator.

5. The establishment of separate ceilings for direct operating costs and indirect operating costs.

6. The use of Service Intensity Indexes to identify the resource needs of given NFs patient mix relative to the needs present in other NFs.

7. The development of Service Intensity Indexes based on:

a. Determination of resource indexes for each patient class that measures relative resource cost.

b. Determination of each NF's average relative resource cost index across all patients.

c. Standardizing the average relative resource cost indexes of each NF across all NF's.

8. The use of the DMAS Long Term Care Information System (LTCIS), assessment form (currently DMAS-95), Virginia Center on Aging Study, the State of Maryland Time and Motion Study of the Provision of Nursing Service in Long Term Care Facilities, and the KPMG Peat Marwick Survey of Virginia long-term care NF's nursing wages to determine the patient class system and resource indexes for each patient class.

9. The establishment of payment rates based on service intensity indexes.

§ 3.2. Conditions for appeal.

A. An appeal shall not be heard until the following conditions are met:

1. Where appeals result from desk or field audit adjustments, the provider shall have received a notification of program reimbursment (NPR) in writing from the DMAS.

2. Any and all moneys due to DMAS shall be paid in full, unless a repayment plan has been agreed to by the Director of the Division of Cost Settlement and Audit.

3. All first level appeal requests shall be filed in writing with the DMAS within 90 days following the receipt of a DMAS notice of program reimbursment that adjustments have been made to a specific cost report.

§ 3.3. Appeal procedure.

A. There shall be two levels of administrative appeal.

B. Informal appeals shall be decided by the Director of the Division of Cost Settlement and Audit after an informal fact finding conference is held. The decision of the Director of Cost Settlement and Audit shall be sent in writing to the provider within 30 days following conclusion of the informal fact finding conference.

C. If the provider disagrees with such initial decision the provider may, at its discretion, file a notice of appeal to the Director of the DMAS. Such notice shall be in writing and filed within 30 days of receipt of the initial decision.

D. Within 30 days of the receipt of such notice of appeal, the director shall appoint a hearing officer to conduct the proceedings, to review the issues and the evidence presented, and to make a written recommendation.

E. The director shall notify the provider of his final decision within 45 days of receipt of the appointed hearing officer's written recommendation, or after the parties have filed exceptions to the recommendations, whichever is later.

F. The director's final written decision shall conclude the provider's administrative appeal.

§ 3.4. Formal hearing procedures.

Formal hearing procedures, as developed by DMAS, shall control the conduct of the formal administrative proceedings.

§ 3.5. Appeals time frames.

Appeal time frames noted throughout this section may be extended for the following reasons;

A. The provider submits a written request prior to the due date requesting an extension for good cause and the DMAS approves the extension.

B. Delays on the part of the NF documented by the DMAS shall automatically extend DMAS's time frame to

the extent of the time delayed.

C. Extensions of time frames shall be granted to the DMAS for good cause shown.

D. When appeals for multiple years are submitted by a NF or a chain organization or common owners are coordinating appeals for more than one NF, the time frames shall be reasonably extended for the benefit of the DMAS.

E. Disputes relating to the time lines established in § 3.3 B or to the grant of extensions to the DMAS shall be resolved by application to the Director of the DMAS or his designee.

PART IV.
INDIVIDUAL EXPENSE LIMITATION.

In addition to operating costs being subject to peer group ceilings, costs are further subject to maximum limitations as defined in VR 460-03-4.1943, Cost Reimbursement Limitations.

PART V.
COST REPORT PREPARATION INSTRUCTIONS.

Instructions for preparing NF cost reports will be provided by the DMAS.

PART VI.
STOCK TRANSACTIONS.

§ 6.1. Stock acquisition.

The acquisition of the capital stock of a provider does not constitute a basis for revaluation of the provider's assets. Any cost associated with such an acquisition shall not be an allowable cost. The provider selling its stock continues as a provider after the sale, and the purchaser is only a stockholder of the provider.

§ 6.2. Merger of unrelated parties.

A. In the case of a merger which combines two or more unrelated corporations under the regulations of the Code of Virginia, there will be only one surviving corporation. If the surviving corporation, which will own the assets and liabilities of the merged corporation, is not a provider, a Certificate of Public Need, if applicable, must be issued to the surviving corporation.

B. The nonsurviving corporation shall be subject to the policies applicable to terminated providers, including those relating to gain or loss on sales of NFs.

§ 6.3. Merger of related parties.

The statutory merger of two or more related parties or the consolidation of two or more related providers resulting in a new corporate entity shall be treated as a transaction between related parties. No revaluation shall be permitted for the surviving corporation.

PART VII.
NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM AND COMPETENCY EVALUATION PROGRAMS (NATCEPs).

§ 7.1. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) amended § 1903(a)(2)(B) of the Social Security Act to fund actual NATCEPs costs incurred by NFs separately from the NF's medical assistance services reimbursement rates.

§ 7.2. NATCEPs costs.

A. NATCEPs costs shall be as defined in VR 460-03-4.1941.

B. To calculate the reimbursement rate, NATCEPs costs contained in the most recently filed cost report shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days.

C. The NATCEPs interim reimbursement rate determined in § 7.2 B shall be added to the prospective operating cost and plant cost components or charges, whichever is lower, to determine the NF's prospective rate. The NATCEPs interim reimbursement rate shall not be adjusted for inflation.

D. Reimbursement of NF costs for training and competency evaluation of nurse aides must take into account the NF's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid shall not be charged for that portion of NATCEPs costs which are properly charged to Medicare or private pay services. The final retrospective reimbursement for NATCEPs costs shall be the reimbursement rate as calculated from the most recently filed cost report by the methodology in § 7.2 B times the Medicaid patient days from the DMAS MMR-240.

E. Disallowance of nonreimbursable NATCEPs costs shall be reflected in the year in which the nonreimbursable costs were claimed.

F. Payments to providers for allowable NATCEPs costs shall not be considered in the comparison of the lower allowable reimbursement or charges for covered services, as outlined in § 2.14 A.

PART VIII.
(Reserved)

PART IX.
USE OF MMR-240.

All providers must use the data from computer printout MMR-240 based upon a 60-day accrual period.

PART X.
COMMINGLED INVESTMENT INCOME.

DMAS shall treat funds commingled for investment purposes in accordance with PRM-15, § 202.6.

PART XI.
PROVIDER NOTIFICATION.

DMAS shall notify providers of State Plan changes affecting reimbursement 30 days prior to the enactment of such changes.

PART XII.
START-UP COSTS AND ORGANIZATIONAL COSTS.

§ 12.1. Start-up costs.

A. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they shall be capitalized as deferred charges and amortized over a 60-month time frame.

B. Start-up costs may include, but are not limited to, administrative and nursing salaries; heat, gas, and electricity; taxes, insurance; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as operating costs must be appropriately classified as such and excluded from start-up costs.

C. Start-up costs that are incurred immediately before a provider enters the Program and that are determined by the provider, subject to the DMAS approval, to be immaterial need not be capitalized but rather may be charged to operations in the first cost reporting period.

D. Where a provider incurs start-up costs while in the Program and these costs are determined by the provider, subject to the DMAS approval, to be immaterial, these costs shall not be capitalized but shall be charged to operations in the periods incurred.

§ 12.2. Applicability.

A. Start-up cost time frames.

1. Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient (whether Medicaid or non-Medicaid) is admitted for treatment, or where the start-up costs apply only to nonrevenue producing patient care functions or nonallowable functions, to the time the areas are used for their intended purposes.

2. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility shall be accumulated in a single deferred charge account and shall be amortized when the first patient is admitted for treatment.

3. If a provider intends to prepare portions of its facility on a piecemeal basis (i.e., preparation of a floor or wing of a provider's facility is delayed), start-up costs shall be capitalized and amortized separately for the portion or portions of the provider's facility prepared during different time periods.

4. Moreover, if a provider expands its NF by constructing or purchasing additional buildings or wings, start-up costs shall be capitalized and amortized separately for these areas.

B. Depreciation time frames.

1. Costs of the provider's facility and building equipment shall be depreciated using the straight line method over the lives of these assets starting with the month the first patient is admitted for treatment.

2. Where portions of the provider's NF are prepared for patient care services after the initial start-up period, those asset costs applicable to each portion shall be depreciated over the remaining lives of the applicable assets. If the portion of the NF is a nonrevenue-producing patient care area or nonallowable area, depreciation shall begin when the area is opened for its intended purpose. Costs of major movable equipment, however, shall be depreciated over the useful life of each item starting with the month the item is placed into operation.

§ 12.3. Organizational costs.

A. Organizational costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organizational costs extend over more than one accounting period and thus affect the costs of future periods of operations.

B. Allowable organizational costs shall include, but not be limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders and fees paid to states for incorporation.

C. The following types of costs shall not be considered allowable organizational costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the

appropriate state or federal authorities, stamp taxes, etc.

D. Allowable organization costs shall generally be capitalized by the organization. However, if DMAS concludes that these costs are not material when compared to total allowable costs, they may be included in allowable indirect operating costs for the initial cost reporting period. In all other circumstances, allowable organization costs shall be amortized ratably over a period of 60 months starting with the month the first patient is admitted for treatment.

PART XIII.
DMAS AUTHORIZATION.

§ 13.1 Access to records.

A. DMAS shall be authorized to request and review, either through a desk or field audit, all information related to the provider's cost report that is necessary to ascertain the propriety and allocation of costs (in accordance with Medicare and Medicaid rules, regulations, and limitations) to patient care and nonpatient care activities.

B. Examples of such information shall include, but not be limited to, all accounting records, mortgages, deeds, contracts, meeting minutes, salary schedules, home office services, cost reports, and financial statements.

C. This access also applies to related organizations as defined in § 2.10 who provide assets and other goods and services to the provider.

PART XIV.
HOME OFFICE COSTS.

§ 14.1. General.

Home office costs shall be allowable to the extent they are reasonable, relate to patient care, and provide cost savings to the provider.

§ 14.2. Purchases.

Provider purchases from related organizations, whether for services, or supplies, shall be limited to the lower of the related organizations actual cost or the price of comparable purchases made elsewhere.

§ 14.3. Allocation of home office costs.

Home office costs shall be allocated in accordance with § 2150.3, PRM-15.

§ 14.4. Nonrelated management services.

Home office costs associated with providing management services to nonrelated entities shall not be recognized as allowable reimburseable cost.

§ 14.5. Allowable and nonallowable home office costs.

Allowable and nonallowable home office costs shall be recognized in accordance with § 2150.2, PRM-15.

§ 14.6. Equity capital.

Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

PART XV.
REFUND OF OVERPAYMENTS.

§ 15.1. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk audit, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS' determination of the overpayment.

§ 15.2. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall be used to reduce the balance of the overpayment.

§ 15.3. Payment schedule.

A. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request in writing an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request in writing an extended repayment schedule.

B. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of DMAS may approve a repayment schedule of up to 36 months.

C. A provider shall have no more than one extended repayment schedule in place at one time. If subsequent audits identify additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amounts.

D. If, during the time an extended repayment schedule

is in effect, the provider ceases to be a participating provider or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

E. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered from interim payments to the provider or by lump sum payments.

§ 15.4. Extension request documentation.

In the written request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

§ 15.5. Interest charge on extended repayment.

A. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

B. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

C. The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

PART XVI.
REVALUATION OF ASSETS.

§ 16.1. Change of ownership.

A. Under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, reimbursement for capital upon the change of ownership of a NF is restricted to the lesser of:

1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year, or

2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

B. To comply with the provisions of COBRA 1985, effective October 1, 1986, the DMAS shall separately apply the following computations to the capital assets of each facility which has undergone a change of ownership:

1. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership), in the Dodge Construction Cost Index, or

2. One-half of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U).

C. Change of ownership is deemed to have occurred only when there has been a bona fide sale of assets of a NF (See § 2.5 B 3 for the definition of "bona fide" sale).

D. Reimbursement for capital assets which have been revalued when a facility has undergone a change of ownership shall be limited to the lesser of:

1. The amounts computed in subsection B above;

2. Appraised replacement cost value; or

3. Purchase price.

VR 460-03-4.1943. Cost Reimbursement Limitations.

§ 1. Foreword.

A. The attached information outlines operating, NATCEPs and plant cost limitations that are not referenced in other regulations.

B. All of the operating cost limitations are further subject to the applicable operating ceilings.

§ 2. Fees.

A. Directors' fees.

1. Although Medicaid does not require a board of directors (Medicare requires only an annual stockholders' meeting), the Program will recognize reasonable costs for directors' meetings related to patient care.

2. It is not the intent of DMAS to reimburse a facility for the conduct of business related to owner's investments, nor is it the intent of the Program to recognize such costs in a closely held corporation where one person owns all stock, maintains all control, and approves all decisions.

3. To receive reimbursement for directors' meetings, the written minutes must reflect the name of the facility for which the meeting is called, the content and purpose of the meeting, members in attendance, the time the meeting began and ended, and the date. If multiple facilities are discussed during a meeting, total allowable director fees, as limited herein, shall be prorated between such facilities.

4. Bona fide directors may be paid an hourly rate of $125 up to a maximum of four hours per month. These fees include reimbursement for time, travel, and services performed.

5. Compensation to owner/administrators who also serve as directors, shall include any and all director's fees paid, subject to the above-referenced limit ~~those~~ set forth in these regulations.

B. Membership fees.

1. These allowable costs will be restricted to membership in health care organizations which promote objectives in the provider's field of health care activities.

2. Membership fees in health care organizations and appropriate professional societies will be allowed for the administrator, owner, and home office personnel.

3. Comparisons will be made with other providers to determine reasonableness of the number of organizations to which the provider will be reimbursed for such membership and the claimed costs, if deemed necessary.

C. Management fees.

1. External management services shall only be reimbursed if they are necessary, cost effective, and nonduplicative of existing NF internal management services.

2. Costs to the provider, based upon a percentage of net or gross revenues or other variations thereof, shall not be an acceptable basis for reimbursement. If allowed, management fees must be reasonable and based upon rates related to services provided.

3. Management fees paid to a related party may be recognized by the Program as the owner's compensation subject to administrator compensation guidelines.

4. A management fees service agreement exists when the contractor provides nonduplicative personnel, equipment, services, and supervision.

5. A consulting service agreement exists when the contractor provides nonduplicative supervisory or management services only.

6. Limits will be based upon comparisons with other similar size facilities or other DMAS guidelines and information.

Effective for all providers' cost reporting periods ending on or after October 1, 1990, a per patient day ceiling for all full service management service costs shall be established. The ceiling limitation for cost reporting periods ending on or after October 1, 1990, through December 31, 1990, shall be the median per patient day cost as determined from information contained in the most recent cost reports for all providers with fiscal years ending through December 31, 1989. These limits will be adjusted annually by the Consumer Price Index effective January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually.

D. Pharmacy consultants fees.

Costs will be allowed to the extent they are reasonable and necessary.

E. Physical therapy fees (for outside services).

Limits are based upon current PRM-15 guidelines.

F. Inhalation therapy fees (for outside services).

Limits are based upon current PRM-15 guidelines.

G. Medical directors' fees.

Costs will be allowed up to the established limit per year to the extent that such fees are determined to be reasonable and proper. This limit will be escalated annually by a the CPI-U effective January 1 of each calendar year to be effective for all providers' cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually. The following limitations apply to the time periods as indicated:

Jan. 1, 1988 - Dec. 31, 1988 - $6,204
Jan. 1, 1989 - Dec. 31, 1989 - $6,625

§ 3. Personal automobile.

A. Use of personal automobiles when related to patient care will be reimbursed at the maximum of the allowable IRS mileage rate when travel is documented.

B. Flat rates for use of personal automobiles will not be reimbursed.

§ 4. Seminar expenses.

These expenses will be treated as allowable costs, if the following criteria are met:

1. Seminar must be related to patient care activities, rather than promoting the interest of the owner or organization.

2. Expenses must be supported by:

a. Seminar brochure,

b. Receipts for room, board, travel, registration, and educational material

3. Only the cost of two persons per facility will be accepted as an allowable cost for seminars which involve room, board, and travel.

§ 5. Legal retainer fees.

DMAS will recognize legal retainer fees if such fees do not exceed the following:

BED SIZE	LIMITATIONS
0 - 50	$100 per month
51 - 100	150 per month
101 - 200	200 per month
201 - 300	300 per month
301 - 400	400 per month

The expense to be allowed by DMAS shall be supported by an invoice and evidence of payment.

§ 6. Architect fees.

Architect fees will be limited to the amounts and standards as published by the Virginia Department of General Services.

§ 7. Administrator/owner compensation.

DMAS ADMINISTRATOR/OWNER COMPENSATION SCHEDULE
JANUARY 1, 1989 - DECEMBER 31, 1989

BED SIZE	NORMAL ALLOWABLE FOR ONE ADMINISTRATOR	MAXIMUM FOR 2 OR MORE ADMINISTRATOR
1-75	32,708	49,063
76-100	35,470	53,201
101-125	40,788	61,181
126-150	46,107	69,160
151-175	51,623	77,436
176-200	56,946	85,415
201-225	60,936	91,399
226-250	64,924	97,388
251-275	68,915	103,370
276-300	72,906	108,375
301-325	76,894	115,344
326-350	80,885	121,330
351-375	84,929	127,394
376 & over	89,175	133,763

These limits will be escalated annually by the CPI-U effective January 1 of each calendar year to be effective for all provider's cost reporting periods ending on or after that date. The limits will be published and distributed to providers annually.

* * *

NOTICE: The forms used in administering the above regulations are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

FORM HCFA-2540-86
Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex - Cost Report Certification (OMB No. 0938-0463)
Worksheet Checklist (Worksheet S-1 Part I and Part II)
Reclassification and Adjustment of Trial Balance of Expenses (Worksheet A)
Reclassifications (Worksheet A-6)
Adjustments to Expenses (Worksheet A-8)
Cost Allocation - General Service Costs (Worksheet B - Part I)
Cost Allocation - Statistical Basis (Worksheet B-1)
Allocation of Capital-Related Costs (Worksheet B - Part II)
Departmental Cost Distribution (Worksheet C)
Outpatient Cost Apportionment (Worksheet C-1)
Inpatient Cost Apportionment (Worksheet D)
Computation of Inpatient Routine Cost (Worksheet D-1)
Apportionment of Malpractice Insurance Cost (Worksheet D-8)
Calculation of Reimbursement Settlement (Worksheet E)
Analysis of Payments to SNF for Services Rendered (Worksheet E-1)
Balance Sheet (Worksheet G)
Statement of Changes in Fund Balances (Worksheet G-1)
Statement of Patient Revenues and Operating Expenses (Worksheet G-2)
Statement of Revenues and Expenses (Worksheet G-3)
Limitation on Federal Participation for Capital Expenditures Questionnaire (Supplemental Worksheet

A-7)
Statement of Costs of Services from Related Organizations (Supplemental Worksheet A-8-1)
Reasonable Cost Determination for Physical Therapy Services Furnished by Outside Suppliers (Supplemental Worksheet A-8-3)
Recovery of Unreimbursed Cost (Supplemental Worksheet E-4)
Balance Sheet for Computation of Return on Equity Capital of Proprietary Providers (Supplemental Worksheet F-1)
Computation of Difference Between Interim Payments and Net Cost of Covered Services (Supplemental Worksheet F-2)
Computation of Return on Equity Capital of Proprietary Providers (Supplemental Worksheet F-3)
Apportionment of Allowable Return on Equity Capital of Proprietary Providers (Supplemental Worksheet F-4)
Allocation of General Service Costs to CORF Centers (Supplemental Worksheet J-1)
Computation of CORF Costs (Supplemental Worksheet J-2)
Calculation of Reimbursement Settlement - CORF Services (Supplemental Worksheet J-3)
Analysis of Payments to Provider-Based CORF for Services Rendered to Program Beneficiaries (Supplemental Worksheet J-4)
Skilled Nursing Facility-Based Hospice Cost and Data Report (Supplemental Worksheet K)
Patient Care Service Utilization Analysis (Supplemental Worksheet K-1)
Analysis of Direct Costs (Supplemental Worksheet K-2)
General Service Cost Allocation Statistics (Supplemental Worksheet K-3)
Hospice General Service Cost Allocation Statistics (Supplemental Worksheet K-4)
Analysis of Shared Services (Supplemental Worksheet K-5)
SNF-Based Home Health Agency Statistical Data (Supplemental Worksheet S-4)
Analysis of Provider-Based Home Health Agency Costs (Supplemental Worksheet H)
Compensation Analysis - Salaries and Wages (Supplemental Worksheet H-1)
Compensation Analysis - Employee Benefits (Payroll Related) (Supplemental Worksheet H-2)
Compensation Analysis - Contracted Services/Purchased Services (Supplemental Worksheet H-3)
Allocation of HHA Malpractice and Administrative and General Costs (Supplemental Worksheet H-4 - PART I)
Apportionment of cost of HHA Services Furnished by Shared Skilled Nursing Facility Departments (Supplemental Worksheet H-4 - PART II)
Apportionment of Patient Service Costs (Supplemental Worksheet H-5)
Apportionment of Patient Service Costs (Supplemental Worksheet H-5, Aggregate Limits)
Calculation of HHA Reimbursement Settlement - Part A and Part B Services (Supplemental Worksheet H-6)
Analysis of Payments to Provider-Based HHAs for Services Rendered to Program Beneficiaries (Supplemental Worksheet H-7)
Recovery of Unreimbursed Cost for Provider-Based HHA (Supplemental Worksheet H-8)
Skilled Nursing Facility-Based CORF Statistical Data (Supplemental Worksheet S-6)

PIRS 1090 Series
Nursing Facility Uniform Cost Report Under Title XIX - Facility Description and Statistical Data (Schedule A)
Certification by Officer or Administrator of Provider (Schedule A-2)
Reclassification and Adjustment of Trial Balance of Expenses (Schedule B)
Classifications (Schedule B-1)
Analysis of Administrative and General - Other (Schedule B-2)
Adjustment to Expenses (Schedule B-4)
Cost Allocation - Employee Benefits (Schedule B-5)
Computation of Title XIX Direct Patient Care Ancillary Service Costs (Schedule C)
Statement of Cost of Services and Related Organizations (Schedule D)
Statement of Compensation of Owners (Schedule E)
Part II Statement of Compensation Administrators and/or Assistant Administrators (Schedule F)
Balance Sheet (Schedule G)
Statement of Patient Revenues (Schedule G-1)
Statement of Operations (Schedule G-2)
Computation of Title XIX (Medicaid) Base Costs and Prospective Rate/PIRS (Schedule H)
Computation of Prospective Direct and Indirect Patient Care Profit Incentive Rates (Schedule H-1)
Debt and Interest Expenses (Schedule K)
Limitation on Federal Participation for Capital Expenditures Questionnaire (Schedule L)
Nurse Aide Training and Competency Evaluation Program Costs and Competency Evaluation Programs (NATCEPs) (Schedule N)

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Title of Regulation: **VR-460-04-8.4. Home and Community Based *Waiver* Services for Elderly and Disabled Individuals.**

Statutory Authority: § 32.1-325 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until May 24, 1991.
(See Calendar of Events section for additional information)

Summary:

The purpose of this proposal is to promulgate permanent regulations regarding Home and Community Based Services for Elderly and Disabled Individuals, to supersede the temporary emergency regulations which became effective on September 10, 1990.

DMAS has provided home and community based services for the elderly and disabled under a Social Security Act waiver approved for the Secretary of Health and Human Services by the Health Care Financing Administrations (HCFA) in 1982. Services included under the waiver were personal care, adult day health care and respite care.

As a condition of the waiver, DMAS was required to render a cost-effectiveness assessment of each individual receiving waivered services every six months. The waiver further required that providers obtain prior approval from DMAS for every increase made to any recipient's plan of care.

Because of the resource-intensive requirements of the waiver affecting both providers and DMAS, the Commonwealth sought an amendment to the waiver which would:

- *eliminate requirement for individual cost-effectiveness assessments while ensuring that the annual aggregate costs to Medicaid are equal to or less than the aggregate costs for institutional care, and*
- *allow providers to use DMAS-developed service limits to serve as standards in developing individual plans of care, which could then be implemented without a prior approval process.*

In seeking the waiver amendment, DMAS reasoned that the providers' ability to develop plans of care within established service limits would eliminate 90% of the requests for prior approval being reviewed by DMAS.

HCFA approved Virginia's request to amend the waiver on May 18, 1990. The Governor approved emergency regulations implementing the amended waiver's provisions effective September 10, 1990, based upon DMAS' need to divert existing resources to the administration of new programs. No adverse impact on either the quality or the cost-effectiveness of services rendered has been experienced since the emergency regulations became effective.

The proposed regulations do not differ substantively from the emergency regulations. They do contain clarification of the definition of adverse action and the DMAS role in assuring compliance with provider participation standards and program policies and procedures. DMAS has also included in these proposed regulations technical corrections to the recipient eligibility requirements which were required by HCFA in the previously discussed waiver approval process.

These regulations will finalize a process that has been underway since early 1990. DMAS has already implemented waiver modifications that are being established in regulations with these changes. Program expenditure estimates for personal care services have not been modified because of these waiver modifications.

VR 460-04-8.4. Home and Community Based Waiver Services for Elderly and Disabled Individuals.

§ 1. Definitions.

The following words and terms, when used in these regulations, shall have the following meanings, unless the context clearly indicates otherwise:

"Activities of daily living" means assistance with personal care tasks (i.e., bathing, dressing, toileting, etc.).

"Adult day health care centers" means a participating provider which offers a community-based day program providing a variety of health, therapeutic and social services designed to meet the specialized needs of those elderly and physically disabled individuals at risk of placement in ~~an intermediate or skilled care~~ *a* nursing ~~home~~ *facility* .

"Adult day health care services" means services designed to prevent institutionalization by providing participants with health, maintenance, and rehabilitation services in a congregate daytime setting.

"Current functional status" means the individual's degree of dependency in performing activities of daily living.

"DMAS" means the Department of Medical Assistance Services.

"Episodic respite care" means relief of the caregiver for a nonroutine, short-term period of time for a specified reason (i.e., respite care offered for seven days, 24 hours a day while the caregiver takes a vacation).

"Home and community-based care" means a variety of in-home services reimbursed by DMAS (personal care, adult day health care and respite care) *authorized under a § 1915(c) waiver* designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the ~~service(s)~~ *service or services* to avoid nursing ~~home~~ *facility* placement. ~~An individual may only receive home and community-based long-term care services up to the amount for which the costs to Medicaid are equal to or less than nursing home care.~~ The Nursing Home Preadmission Screening Team or Department of Medical Assistance Services shall give prior authorization for any Medicaid-reimbursed home and community-based care.

"Nursing home preadmission screening" means the process to: (i) evaluate the medical, nursing, and social needs of individuals referred for preadmission screening,

(ii) analyze what specific services the individuals need, (iii) evaluate whether a service or a combination of existing community services is available to meet the individuals' needs, and (iv) authorize Medicaid funded nursing home or community-based care for those individuals who meet nursing facility level of care and require that level of care.

"Nursing Home Preadmission Screening Committee/Team" means the entity contracted with the DMAS which is responsible for performing nursing home preadmission screening. For individuals in the community, this entity is a committee comprised of staff from the local health department and local DSS. For individuals in an acute care facility who require screening, the entity is a team of nursing and social work staff. A physician must be a member of both the local committee or acute care team.

"Participating provider" means an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by DMAS, and has a current, signed contract with DMAS.

"Personal care agency" means a participating provider which renders services designed to prevent or reduce inappropriate institutional care by providing eligible individuals with personal care aides who provide personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable the individual to remain at or return home rather than enter ~~an intermediate or skilled~~ *a* nursing care facility. Personal care services include assistance with personal hygiene, nutritional support, and the environmental maintenance necessary for recipients to remain in their homes.

"Plan of Care" means the written plan of services certified by the screening team physician as needed by the individual to ensure optimal health and safety for the delivery of home and community-based care.

"Professional staff" means the director, activities director, registered nurse, or therapist of an adult day health care center.

"Respite care" means services specifically designed to provide a temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. Respite care services include assistance with personal hygiene, nutritional support and environmental maintenance authorized as either episodic, temporary relief or as a routine periodic relief of the caregiver.

"Respite care agencies" means a participating provider which renders services designed to prevent or reduce inappropriate institutional care by providing eligible individuals with respite care aides who provide respite care services.

"Routine respite care" means relief of the caregiver on a periodic basis over an extended period of time to allow the caregiver a routine break from continuous care (i.e., respite care offered one day a week for six hours).

"Staff" means professional and aide staff of an adult day health care center.

"State Plan for Medical Assistance" or *"the Plan"* means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

§ 2. General coverage and requirements for all home and community-based care *waiver* services.

A. Coverage statement.

1. Coverage shall be provided under the administration of the ~~Department of Medical Assistance Services~~ *DMAS* for elderly and disabled individuals who would otherwise require the ~~intermediate or skilled~~ level of ~~nursing~~ care *provided in a nursing facility* .

2. These services shall be medically appropriate ; ~~cost effective~~ and necessary to maintain these individuals in the community.

3. Under this § 1915(c) waiver, DMAS waives §§ 1902(a)(10)(B) and 1902(a)(10)(C)(1)(iii) of the Social Security Act related to comparability and statewideness of services.

B. Patient qualification and eligibility requirements.

1. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy and the medically needy. Virginia has elected to cover the optional categorically needy group under 42 CFR 435.211, 435.231 and 435.217. The income level used for 435.211, 435.231 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person.

a. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. ~~The medically needy individuals participating in the waiver will also be considered as if they were institutionalized for the purpose of applying the institutional deeming rules.~~ *All recipients under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and be Medicaid eligible in an institution. The deeming rules are applied to waiver eligible individuals as if the individual were residing in an institution or would require that level of care.*

~~b. Virginia will treat the income of an eligible~~

~~individual who receives home and community-based care services under 42 CFR 435.217 using the methodology in 42 CFR 435.735 to reduce the agency's payment for home and community-based services. The following amounts from the individual's total income (including amounts disregarded in determining eligibility) will be deducted:~~

~~(1) For the individual's maintenance needs, the current Supplemental Security Income (SSI) payment standard for one individual (the categorically needy income standard for one).*~~

~~* Although Virginia has elected to apply more restrictive eligibility requirements than SSI, Virginia does not apply a more restrictive income standard.~~

~~(2) For an individual with a spouse living in the home, an additional amount for the maintenance needs of the spouse based upon a reasonable assessment of need but not to exceed the current Supplemental Security Income payment for one individual (the categorically needy income standard for one).~~

~~(3) For an individual with a family at home, an additional amount for the maintenance needs of the family based upon a reasonable assessment of need but not to exceed the medically needy income standard for a family of the same size.~~

~~(4) Amounts for incurred expenses for Medicare and other health insurance premiums, deductibles, or coinsurance charges.~~

~~(5) Amounts for incurred expenses for necessary medical or remedial care not subject to payment by a third party recognized under state law but not covered under the state's Medicaid Plan within the same reasonable limits established under the State Plan for institutionalized individuals.~~

b. Virginia shall reduce its payment for home and community-based services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amount disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the guidelines in 42 CFR 435.735 and § 1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community based waiver services by the amount that remains after the deductions listed below:

(1) For individuals to whom § 1924(d) applies (Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B)) deduct the following in the following order:

(a) An amount for the maintenance needs of the individual which is equal to the categorically needy income standard for a noninstitutionalized individual.

(b) For an individual with only a spouse at home, the community spousal income allowance determined in accordance with § 1924(d) of the Social Security Act.

c. For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with § 1924(d) of the Social Security Act.

d. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other healthy insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but covered under the Plan.

2. For individuals to whom § 1924(d) does not apply, deduct the following in the following order:

(a) An amount for the maintenance needs of the individual which is equal to the categorically needy income standards for a noninstitutionalized individual.

(b) For an individual with a family at home, an additional amount for the maintenance needs of the family which shall be equal to the medically needy income standard for a family of the same size.

(c) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but covered under the state Medical Assistance Plan.

C. Assessment and authorization of home and community-based care services.

1. To ensure that Virginia's home and community-based care waiver programs serve only individuals who would otherwise be placed in a nursing ~~home~~ *facility* , home and community-based care services shall be considered only for individuals who are seeking nursing ~~home~~ *facility* admission or for individuals who are at imminent risk of nursing ~~home~~ *facility* admission. Home and community-based care services shall be the critical service that enables the individual to remain at home rather than being placed in a nursing ~~home~~ *facility* .

2. The individual's status as an individual in need of home and community-based care services shall be determined by the Nursing Home Preadmission Screening Team after completion of a thorough assessment of the individual's needs and available support. Screening and preauthorization of home and community-based care services by the Nursing Home Preadmission Screening Committee/Team or DMAS staff is mandatory before Medicaid will assume payment responsibility of home and community-based care services.

3. An essential part of the Nursing Home Preadmission Screening Team's assessment process is determining the level of care required by applying existing criteria for ~~skilled and intermediate~~ nursing , ~~home~~ *facility* care according to established Nursing Home Preadmission Screening process.

4. The team shall explore alternative settings and services to provide the care needed by the individual. If nursing ~~home~~ *facility* placement or a combination of other services is determined to be appropriate, the screening team shall initiate referrals for service. If Medicaid-funded home and community-based care services are determined to be the critical service to delay or avoid nursing ~~home~~ *facility* placement, the screening team shall develop an appropriate plan of care ; ~~compute cost effectiveness~~ and initiate referrals for service.

5. ~~To ensure that Virginia's home and community-based care services continue to be a cost-effective alternative to institutionalization, home and community-based care services shall be considered only for individuals for whom the cost of Medicaid-reimbursed home and community-based care would not exceed the Medicaid cost of institutional care.~~ *Reserved.*

6. Home and community-based care services shall not be offered to any individual who resides in ~~an intermediate or skilled~~ *a* nursing facility, an intermediate facility for the mentally retarded, a hospital, or an adult home licensed by the DSS.

7. Medicaid will not pay for any home and community-based care services delivered prior to the authorization date approved by the Nursing Home Preadmission Screening Committee/Team.

8. Any authorization and Plan of Care for home and community-based care services will be subject to the approval of the DMAS prior to Medicaid reimbursement for waiver services.

§ 3. General conditions and requirements for all home and community-based care participating providers.

A. General requirements.

Providers approved for participation shall, at a minimum, perform the following activities:

1. Immediately notify DMAS, in writing, of any change in the information which the provider previously submitted to DMAS.

2. Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the ~~service(s)~~ *service or services* required and participating in the Medicaid Program at the time the service ~~was~~ *or services were* performed.

3. Assure the recipient's freedom to reject medical care and treatment.

4. Accept referrals for services only when staff is available to initiate services.

5. Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, religion, or national origin and of Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of a handicap.

6. Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.

7. Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

8. Accept Medicaid payment from the first day of eligibility.

9. Accept as payment in full the amount established by the DMAS.

10. Use Program-designated billing forms for submission of charges.

11. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope and details of the health care provided.

a. Such records shall be retained for at least five years from the last date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years.

b. Policies regarding retention of records shall apply even if the agency discontinues operation. DMAS shall be notified in writing of storage, location, and

procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia.

12. Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

13. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid.

14. Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients.

15. Change of ownership. When ownership of the provider agency changes, DMAS shall be notified within 15 calendar days.

B. Requests for participation.

Requests will be screened to determine whether the provider applicant meets the basic requirements for participation.

C. Provider participation standards.

For DMAS to approve contracts with home and community-based care providers the following standards shall be met:

1. Staffing requirements,

2. Financial solvency,

3. Disclosure of ownership, and

4. Assurance of comparability of services.

D. Adherence to provider contract and special participation conditions.

In addition to compliance with the general conditions and requirements, all providers enrolled by the Department of Medical Assistance Services shall adhere to the conditions of participation outlined in their individual provider contracts.

E. Recipient choice of provider agencies.

If there is more than one approved provider agency in the community, the individual will have the option of selecting the provider agency of their choice.

F. Termination of provider participation.

DMAS may administratively terminate a provider from participation upon 60 days' written notification. DMAS may also cancel a contract immediately or may give notification in the event of a breach of the contract by the provider as specified in the DMAS contract. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

G. Reconsideration of adverse actions.

Adverse actions may include, but shall not be limited to: disallowed payment of claims for services rendered which are not in accordance with DMAS policies and procedures, caseload restrictions, and contract limitations or termination. The following procedures will be available to all providers when DMAS takes adverse action ~~which includes termination or suspension of the provider agreement.~~ :

1. The reconsideration process shall consist of three phases:

a. A written response and reconsideration to the preliminary findings,

b. The informal conference, and

c. The formal evidentiary hearing.

2. The provider shall have 30 days to submit information for written reconsideration, 15 days from the date of the notice to request the informal conference, and 15 days to request the formal evidentiary hearing.

3. An appeal of adverse actions shall be heard in accordance with the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) and that the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of the final agency determination shall be made in accordance with the Administrative Process Act.

H. Participating provider agency's responsibility for the recipient information form (DMAS-122).

It is the responsibility of the provider agency to notify DMAS and the DSS, in writing, when any of the following circumstances occur:

1. Home and community-based care services are implemented,

2. A recipient dies,

3. A recipient is discharged or terminated from services, or

4. Any other circumstances (including hospitalization) which cause home and community-based care services

to cease or be interrupted for more than 30 days.

I. Changes or termination of care.

1. Decreases in amount of authorized care by the provider agency.

a. The provider agency may decrease the amount of authorized care only if the recipient and the participating provider both agree that a decrease in care is needed and that the amount of care in the revised plan of care is appropriate.

b. The participating provider is responsible for devising the new Plan of Care and calculating the new hours of service delivery.

c. The individual responsible for supervising the recipient's care shall discuss the decrease in care with the recipient or family, or both, document the conversation in the recipient's record, and shall notify the recipient or family of the change by letter.

d. If the recipient disagrees with the decrease proposed, the DMAS shall be notified to conduct a special review of the recipient's service needs.

2. Increases in amount of authorized care. If a change in the recipient's condition (physical, mental, or social) necessitates an increase in care, the participating provider shall ~~contact the DMAS Utilization Review Analyst assigned to the provider who will~~ assess the need for increase and, if appropriate, ~~authorized the increase. If the increase is needed immediately for an emergency situation, a begin and an end date will be provided by DMAS for the temporary emergency increase~~ *develop a plan of care for services to meet the changed needs. The provider may implement the increase in hours without approval from DMAS as long as the amount of service does not exceed the amount established by DMAS as the maximum for the level of care designated for that recipient. Any increase to a recipient's plan of care which exceeds the number of hours allowed for that recipient's level of care or any change in the recipient's level of care must be preapproved by the DMAS utilization review analyst assigned to the provider .*

3. Nonemergency termination of home and community-based care services by the participating provider. The participating provider shall give the recipient or family five days written notification of the intent to terminate services. The letter shall provide the reasons for and effective date of the termination. The effective date of services termination shall be at least five days from the date of the termination notification letter.

4. Emergency termination of home and community-based care services by the participating provider. In an emergency situation when the health and safety of the recipient or provider agency personnel is endangered the DMAS must be notified prior to termination. The five-day written notification period shall not be required.

5. DMAS termination of home and community-based care services. The effective date of termination will be at least 10 days from the date of the termination notification letter. DMAS has the responsibility and the authority to terminate home and community-based care services to the recipient for any of these reasons:

a. The home and community-based care service is not the critical alternative to prevent or delay institutional placement.

b. The recipient no longer meets the level-of-care criteria.

c. The recipient's environment does not provide for his health, safety, and welfare.

d. An appropriate and cost-effective plan of care cannot be developed.

J. Suspected abuse or neglect.

Pursuant to § 63.1-55.3 of the Code of Virginia, if a participating provider agency knows or suspects that a home and community-based care recipient is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse/neglect/exploitation shall report this to the local DSS.

K. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring or compliance with provider participation standards and DMAS policies and annually recertify each provider for contract renewal with DMAS to provide home and community-based services. A provider's noncompliance with DMAS policies and procedures, as required in the provider's contract, may result in a written request from DMAS for a corrective action plan which details the steps the provider will take and the length of time required to achieve full compliance with deficiencies which have been cited.

§ 4. Adult day health care services.

The following are specific requirements governing the provision of adult day health care:

A. General.

Adult day health care services may be offered to individuals in a congregate daytime setting as an alternative to more costly institutional care. Adult day health care may be offered either as the sole home and community-based care service that avoids

institutionalization or in conjunction with personal care or respite care, or both. When the individual referred for adult day health care is already receiving another home and community-based care service, the DMAS utilization review staff shall assess the need for the additional home and community-based care service and authorize the service if it is deemed necessary to avoid institutionalization.

B. Special provider participation conditions.

In order to be a participating provider, the adult day health care center shall :

1. Be an adult day care center licensed by DSS. A copy of the current license shall be available to the DMAS for verification purposes prior to the applicant's enrollment as a Medicaid provider and shall be available for DMAS review prior to yearly contract renewal.

2. Adhere to the DSS adult day care center standards. The DMAS special participation conditions included here are standards imposed in addition to DSS standards which shall be met in order to provide Medicaid adult day health care services.

3. Be open and provide services for a minimum of 10 hours a day Monday through Friday. The participant may attend the center all or a portion of that day according to the Plan of Care developed for that individual. The center shall be able to provide a separate room or area equipped with one bed or cot for every six Medicaid adult day health care participants.

4. Employ sufficient interdisciplinary staff to adequately meet the health, maintenance, and safety needs of each participant. The following staff are required by DMAS:

a. The adult day health care center shall maintain a minimum staff-participant ratio of one staff member to every six participants (Medicaid and other participants).

b. There shall be at least two staff persons at the center at all times when there are Medicaid participants in attendance.

c. In the absence of the director, a professional staff member shall be designated to supervise the program.

d. Volunteers shall be included in the staff ratio only when they conform to the same standards and requirements as paid staff and meet the job description standards of the organization.

e. Any center that is collocated with another facility shall count only its own separate identifiable staff in the center's staff/participant ratio.

f. The adult day health care center shall employ the following:

(1) A director who shall be responsible for overall management of the center's programs. This individual shall be the provider contact person for DMAS staff and shall be responsible for contracting, and receipt and response to communication from DMAS. The director shall be responsible for assuring the initial development of the Plan of Care for adult day health care participants. The director has ultimate responsibility for directing the center program and supervision of its employees. The director can serve as activities director also if those qualifications are met.

(2) An activities director who shall be responsible for directing recreational and social activities for the adult day health care participants.

(3) Program aides who shall be responsible for overall assistance with care and maintenance of the participant (assistance with activities of daily living, recreational activities and other health and therapeutic related activities).

g. The adult day health care center shall employ or subcontract with a registered nurse who shall be responsible for administering and monitoring the health needs of the adult day health care participants. The nurse shall be responsible for the planning, organization, and management of a treatment plan involving multiple services where specialized health care knowledge shall be applied. The nurse shall be present a minimum of two hours each day at the adult day health care center to render direct services to Medicaid adult day health care participants. The DMAS may require the nurse's presence at the adult day health care center for more than two hours each day depending on the number of participants in attendance and according to the medical and nursing needs of the participants. Although the DMAS does not require that the nurse be a full-time staff position, there shall be a nurse available, either in person or by telephone at a minimum, to the center's participants during all times the center is in operation.

h. The director shall assign a professional staff member to act as adult day health care coordinator for each participant and shall document in the participant's file the identity of the care coordinator. The adult day health care coordinator shall be responsible for management of the participant's plan of care and for its review with the program aides.

C. Minimum qualifications of adult day health care staff.

Documentation of all staffs' credentials shall be

maintained in the provider agency's personnel file for review by DMAS staff.

1. Program aide. Each program aide hired by the provider agency shall be screened to ensure compliance with minimum qualifications as required by DMAS. The aide shall, at a minimum, have the following qualifications:

a. Be able to read and write.

b. Be physically able to do the work.

c. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of possible abuse neglect or exploitation of incapacitated or older adults and children .

d. Have satisfactorily completed an educational curriculum related to the needs of the elderly and disabled. Acceptable curriculum are offered by educational institutions, nursing homes, and hospitals. Curriculum titles include: Nurses Aide, Geriatric Nursing Assistant, and Home Health Aide. Documentation of successful completion shall be maintained in the aide's personnel file and be available for review by the DMAS staff. Training consistent with DMAS training guidelines may also be given by the center's professional staff. The content of the training shall be approved by DMAS prior to assignment of the aide to a Medicaid participant.

2. Registered nurse. The registered nurse shall:

a. Be registered and licensed to practice nursing in the Commonwealth of Virginia.

b. Have two years of related clinical experience (which may include work in an acute care hospital, rehabilitation hospital, or nursing home).

c. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of possible abuse or neglect of incompetent or incapacitated individuals.

3. Activities director. The activities director shall:

a. Have a minimum of a Bachelors degree from an accredited college or university with a major in recreational therapy, occupational therapy, or a related field such as art, music, or physical education.

b. Have one year of related clinical experience which may include work in an acute care hospital, rehabilitation hospital, nursing home, or have completed a course of study including any prescribed internship in occupational, physical, and recreational therapy or music, dance, art therapy, or physical education.

c. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of possible abuse, neglect or exploitation of incapacitated or older adults and children.

4. Director. The director shall meet the qualifications specified in the DSS standards for adult day care for directors.

D. *Service* responsibilities of the adult day health care center *and staff duties* are:

1. Aide responsibilities. The aide shall be responsible for assisting with activities of daily living, supervising the participant, and assisting with the management of the participant's Plan of Care.

2. Nursing responsibilities. These services shall include:

a. Periodic evaluation of the nursing needs of each participant,

b. Provision of the indicated nursing care and treatment, and

c. Monitoring, recording, and administering of prescribed medications or supervising the individual in self-administered medication.

3. Rehabilitation services coordination responsibilities. These services are designed to ensure the participant receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include the coordination and implementation of physical therapy, occupational therapy, and speech-language therapy. Rendering of the specific Rehabilitative Therapy is not included in the ADHC center's fee for service but must be rendered as a separate service by a DMAS approved rehabilitative provider.

4. Transportation responsibilities. Every DMAS approved adult day health care center shall provide transportation when needed in emergency situations (i.e., primary caregiver has an accident and cannot transport the participant home) for all Medicaid participants to and from their homes. Any adult day health care center which is able to provide participants with transportation routinely to and from the center can be reimbursed by DMAS based on a per trip (to and from the participant's residence) fee. This reimbursement for transportation shall be preauthorized by either the Nursing Home Preadmission Screening Team or DMAS utilization review staff.

5. Nutrition responsibilities. The adult day health care center shall provide one meal per day which supplies one-third of the daily nutritional requirements. Special

diets and counseling shall be provided to Medicaid participants as necessary.

6. Adult day health care coordination. The designated adult day health care coordinator shall coordinate the delivery of the activities as prescribed in the participants' Plans of Care and keep it updated, record 30-day progress notes, and review the participants' daily logs each week.

7. Recreation and social activities responsibilities. The adult day health care center shall provide planned recreational and social activities suited to the participants' needs and designed to encourage physical exercise, prevent deterioration, and stimulate social interaction.

E. Documentation required.

The adult day health care center shall maintain all records of each Medicaid participant. These records shall be reviewed periodically by DMAS staff. At a minimum, these records shall contain:

1. Long-term care Information Assessment Instrument, the Nursing Home Preadmission Screening Authorization, and the Screening Team Plan of Care.

2. Interdisciplinary Plan of Care developed by adult day health care center professional staff and the participant and relevant support persons.

3. Documentation of interdisciplinary staff meetings which shall be held at least every three months to reassess each participant and evaluate the adequacy of the adult day health care Plan of Care and make any necessary revisions.

4. At a minimum, 30-day goal oriented progress notes recorded by the individual designated as the adult day health care coordinator. If a participant's condition and treatment plan changes more often, progress notes shall be written more frequently than every 30 days.

5. The adult day health care center shall obtain a rehabilitative progress report and updated treatment plan from all professional disciplines involved in the participant's care every 30 days (physical therapy, speech therapy, occupational therapy, home health and others).

6. Daily log of ~~service~~ *services* provided. The daily log shall contain the specific services delivered by adult day health care center staff. The log shall also contain the arrival and departure time of the participant and be signed weekly by the participant and an adult day health care center professional staff member. The daily log shall be completed on a daily basis, neither before nor after the date of service delivery. At least once a week, a staff member shall chart significant comments regarding care given to the participant. If the staff member writing comments is different from the staff signing the weekly log, that staff member shall sign the weekly comments.

7. All correspondence to the participant and to DMAS.

8. All DMAS utilization review forms and plans of care.

§ 5. Personal care services.

The following requirements govern the provision of personal care services : .

A. General.

Personal care services may be offered to individuals in their homes as an alternative to more costly institutional care. Personal care may be offered either as the sole home and community-based care service that avoids institutionalization or in conjunction with adult day health care or respite care, or both. When the individual referred for personal care is already receiving another home and community-based care service, the DMAS utilization review staff shall assess the need for the additional home and community-based care service and authorize the service if it is deemed necessary to avoid institutionalization.

B. Special provider participation conditions.

The personal care provider shall:

1. Demonstrate a prior successful health care delivery.

2. Operate from a business office.

3. Employ (or subcontract with) and directly supervise a registered nurse (RN) who will provide ongoing supervision of all personal care aides.

a. The RN shall be currently licensed to practice in the Commonwealth of Virginia and have at least two years of related clinical nursing experience (which may include work in an acute care hospital, public health clinic, home health agency, or nursing home).

b. The RN supervisor shall make an initial assessment home visit prior to the start of care for all new recipients admitted to personal care.

c. The RN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services. A minimum frequency of these visits is every 30 days.

d. During visits to the recipient's home, the RN shall observe, evaluate, and document the adequacy and appropriateness of personal care services with regard to the recipient's current functioning status, medical, and social needs. The personal care aide's record shall be reviewed and the recipient's (or

family's) satisfaction with the type and amount of service discussed. The RN summary shall note:

(1) Whether personal care services continue to be appropriate, (2) Whether the plan is adequate to meet the need or changes are indicated in the plan,

(3) Any special tasks performed by the aide and the aide's qualifications to perform these tasks,

(4) Recipient's satisfaction with the service,

(5) Hospitalization or change in medical condition or functioning status,

(6) Other services received and their amount, and

(7) The presence or absence of the aide in the home during the RN's visit.

e. The registered nurse shall be available to the personal care aide for conference pertaining to individuals being served by the aide and shall be available to aides by telephone at all times that the aide is providing services to personal care recipients. Any change in the identity of the RN providing coverage shall be reported immediately to DMAS.

f. The RN supervisor shall evaluate the aides' performance and the recipient's individual needs to identify any gaps in the aides' abilities to function competently and shall provide training as indicated.

4. Employ and directly supervise personal care aides who will provide direct care to personal care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by DMAS. Each aide shall:

a. Be able to read and write.

b. Complete 40 hours of training consistent with DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards.

c. Be physically able to do the work.

d. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of possible abuse, neglect or exploitation of incapacitated or older adults and children.

e. Not be a member of the recipient's family (e.g., family is defined as parents, spouses, children, siblings, grandparents, and grandchildren).

C. Provider inability to render services and substitution of aides.

1. When a personal care aide is absent and the agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients. The agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient to another agency. If no other provider agency is available, the provider agency shall notify the recipient or family so they may contact the local health department to request a Nursing Home Preadmission Screening if nursing home placement is desired.

2. During temporary, short-term lapses in coverage (not to exceed two weeks in duration), the following procedure shall apply:

a. The personal care agency having recipient responsibility shall provide the registered nurse supervision for the substitute aide.

b. The agency providing the substitute aide shall send to the personal care agency having recipient care responsibility a copy of the aide's signed daily records signed by the recipient.

c. The provider agency having recipient responsibility shall bill DMAS for services rendered by the substitute aide.

3. If a provider agency secures a substitute aide, the provider agency shall be responsible for ensuring that all DMAS requirements continue to be met, including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS requirements.

D. Required documentation in recipients' records.

The provider agency shall maintain all records of each personal care recipient. At a minimum these records shall contain:

1. *The most recently updated* Long-Term Care Assessment Instrument, the Preadmission Screening Authorization, the Screening Team Plan of Care, all provider agency plans of care, and all DMAS-122's.

2. All DMAS utilization review forms and plans of care.

3. Initial assessment by the RN supervisory nurse completed prior to or on the date services are initiated.

4. Nurses' notes recorded and dated during any contacts with the personal care aide and during supervisory visits to the recipient's home.

5. All correspondence to the recipient and to DMAS.

6. Reassessments made during the provision of services.

7. Contacts made with family, physicians, DMAS, formal, informal service providers and all professionals concerning the recipient.

8. All personal care aide records. The personal care aide record shall contain:

a. The specific services delivered to the recipient by the aide and the recipient's responses,

b. The aide's arrival and departure times,

c. The aide's weekly comments or observations about the recipient to include observations of the recipient's physical and emotional condition, daily activities, and responses to services rendered,

d. The aide's and recipient's weekly signatures to verify that personal care services during that week have been rendered, and

Signatures, times and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered.

9. All recipient progress reports.

E. Recipient progress report.

The provider is required to submit to DMAS annually for every recipient a recipient progress report, an updated Long-Term Care Assessment and four aide log sheets. This information is used to assess the recipient's ongoing need for Medicaid funded long-term care and appropriateness and adequacy of services rendered.

§ 6. Respite care services.

These requirements govern the provision of respite care services.

A. General.

Respite care services may be offered to individuals in their homes as an alternative to more costly institutional care. Respite care is distinguished from other services in the continuum of long-term care because it is specifically designed to focus on the need of the caregiver for temporary relief. Respite care may only be offered to individuals who have a primary caregiver living in the home who requires a temporary relief to avoid institutionalization of the individual. The authorization of respite care is limited to 30 24-hour days over a 12-month period. Reimbursement shall be made on an hourly basis for any amount authorized up to eight hours. Any amount over an eight-hour day will be reimbursed on a per diem basis. The option of respite care may be offered either as a secondary home and community-based care service to those individuals who receive either personal care or adult day health care or as the sole home and community-based care service received in lieu of nursing home placement.

B. Special provider participation conditions.

To be approved for respite care contracts with DMAS, the respite care provider shall:

1. Demonstrate a prior successful health care delivery.

2. Operate from a business office.

3. Employ (or subcontract with) and directly supervise a registered nurse (RN) who will provide ongoing supervision of all respite care aides.

a. The RN shall be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience (which may include work in an acute care hospital, public health clinic, home health agency, or nursing home).

b. Based on continuing evaluations of the aides' performance and the recipients' individual needs, the RN supervisor shall identify any gaps in the aides' abilities to function competently and shall provide training as indicated.

c. The RN supervisor shall make an initial assessment visit prior to the start of care for any recipient admitted to respite care.

d. The RN shall make supervisory visits as often as needed to ensure both quality and appropriateness of services.

(1) When respite care services are received on a routine basis, the minimum acceptable frequency of these visits shall be every 30 days.

(2) When respite care services are not received on a routine basis, but are episodic in nature (i.e., respite care offered for one full week during a six-month period), the RN shall not be required to conduct a supervisory visit every 30 days. Instead, the nurse supervisor shall conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within after the respite care period has concluded.

(3) When respite care services are routine in nature and offered in conjunction with personal care, the 30-day supervisory visit conducted for personal care may serve as the RN visit for respite care. However, the RN supervisor shall document supervision of respite care separately. For this purpose, the same recipient record can be used with

a separate section for respite care documentation.

e. During visits to the recipient's home, the RN shall observe, evaluate, and document the adequacy and appropriateness of respite care services with regard to the recipient's current functioning status, medical, and social needs. The respite care aide's record shall be reviewed and the recipient's (or family's) satisfaction with the type and amount of service discussed. The RN shall document in a summary note:

(1) Whether respite care services continue to be appropriate,

(2) Whether the plan of care is adequate to meet the recipient's needs or if changes need to be made in it,

(3) The recipient's satisfaction with the service,

(4) Any hospitalization or change in medical condition or functioning status,

(5) Other services received and their amount, and

(6) The presence or absence of the aide in the home during the visit.

f. In all cases, the RN shall be available to the respite care aide for conference pertaining to recipient's being served by the aide.

g. The RN providing supervision to respite care aides shall be available to them by telephone at all times that services are being provided to respite care recipients. Any lapse in RN coverage shall be reported immediately to DMAS.

4. Employ and directly supervise respite care aides who provide direct care to respite care recipients. Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by DMAS. Each aide must:

a. Be able to read and write.

b. Have completed 40 hours of training consistent with DMAS standards. Prior to assigning an aide to a recipient, the provider agency shall ensure that the aide has satisfactorily completed a training program consistent with DMAS standards.

c. Be evaluated in his job performance by the RN supervisor.

d. Have the physical ability to do the work.

e. Have a satisfactory work record, as evidenced by references from prior job experience, including no evidence of possible abuse or neglect of incompetent or incapacitated individuals.

f. Not be a member of a recipient's family (e.g., family is defined as parents, spouses, siblings, grandparents, and grandchildren).

5. The Respite Care Agency may employ a licensed practice nurse to deliver respite care services which shall be reimbursed by DMAS under the following circumstances:

a. The individual receiving care has a need for routine skilled care which cannot be provided by unlicensed personnel. These individuals would typically require a skilled level of care if in a nursing home (i.e., recipients on a ventilator, recipients requiring nasogastric, or gastrostomy feedings, etc.).

b. No other individual in the recipient's support system is able to supply the skilled component of the recipient's care during the caregiver's absence.

c. The recipient is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver.

d. The agency can document the circumstances which require the provision of services by an LPN.

C. Inability to provide services and substitution of aides.

When a respite care aide is absent and the respite care provider agency has no other aide available to provide services, the provider agency is responsible for ensuring that services continue to recipients.

1. If a provider agency cannot supply a respite care aide to render authorized services, the agency may either obtain a substitute aide from another agency, if the lapse in coverage is to be less than two weeks in duration, or may transfer the recipient's care to another agency.

2. If no other provider agency is available who can supply an aide, the provider agency shall notify the recipient or family so that they may contact the local health department to request a Nursing Home Preadmission Screening if nursing home placement is desired.

3. During temporary, short-term lapses in coverage, which shall not exceed two weeks in duration, a substitute aide may be secured from another respite care provider agency or other home care agency. Under these circumstances, the following procedures apply:

a. The respite care agency having recipient responsibility shall be responsible for providing the

RN supervision for the substitute aide;

b. The agency providing the substitute aide shall send to the respite care agency having recipient care responsibility a copy of the aide's daily records signed by the recipient and the substitute aide. All documentation of services rendered by the substitute aide shall be in the recipient's record. The documentation of the substitute aide's qualifications shall also be obtained and recorded in the personnel files of the agency having recipient care responsibility.

c. The provider agency having recipient responsibility shall bill DMAS for services rendered by the substitute aide. (The two agencies involved shall negotiate the financial arrangements of paying the substitute aide.)

4. Substitute aides obtained from other agencies may be used only in cases where no other arrangements can be made for recipient respite care services coverage and may be used only on a temporary basis. If a substitute aide is needed for more than two weeks, the case shall be transferred to another respite care provider agency that has the aide capability to serve the recipient(s).

5. If a provider agency secures a substitute aide it is the responsibility of the provider agency having recipient care responsibility to ensure that all DMAS requirements continue to be met, including documentation of services rendered by the substitute aide and documentation that the substitute aide's qualifications meet DMAS requirements.

D. Required documentation for recipients records.

The provider agency shall maintain all records of each respite care recipient. These records shall be separated from those of other non-home and community-based care services, such as companion services or home health. These records shall be reviewed periodically by the DMAS staff. At a minimum these records shall contain:

1. Long-Term Care Assessment Instrument, the Nursing Home Preadmission Screening Authorization, all Respite Care Assessment and Plans of Care, and all DMAS-122's.

2. All DMAS utilization review forms and plans of care.

3. Initial assessment by the RN supervisory nurse completed prior to or on the date services are initiated.

4. Registered nurse's notes recorded and dated during significant contacts with the respite care aide and during supervisory visits to the recipient's home.

5. All correspondence to the recipient and to DMAS.

6. Reassessments made during the provision of services.

7. Significant contacts made with family, physicians, DMAS, and all professionals concerning the recipient.

8. Respite care aide record of services rendered and recipient's responses. The aide record shall contain:

a. The specific services delivered to the recipient by the respite care aide or LPN, and the recipient's response,

b. The arrival and departure time of the aide for respite care services only,

c. Comments or observations recorded weekly about the recipient. Aide comments shall include but not be limited to observation of the recipient's physical and emotional condition, daily activities, and the recipient's response to services rendered,

d. The signature by the aide or LPN, and the recipient once each week to verify that respite care services have been rendered.

Signature, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered

9. Copies of all aide records shall be subject to review by state and federal Medicaid representatives.

10. If a respite care recipient is also receiving any other service (meals on wheels, companion, home health services, etc.) the respite care record shall indicate that these services are also being received by the recipient.

E. Authorization of combined services.

Respite care, when offered in conjunction with another home and community-based care service, is considered by DMAS a secondary home and community-based care service necessary for the recipients' continued maintenance in the community. Respite care is only available to caregivers as an adjunct to another primary home and community-based care service under the following conditions:

1. The individual has been authorized to receive a primary home and community-based care service by the Nursing Home Preadmission Screening Team and such care has been initiated.

2. The primary home and community-based care services offered to the individual are determined to be insufficient to prevent the breakdown of the caregiver due to the physical burden and emotional stress of

providing continuous support and care to the dependent individual.

~~3. The amount of respite care needed, when added to the cost of other home and community-based care services, still maintains overall individual cost effectiveness on an annual basis.~~

F. Provider responsibility.

The provider of the primary home and community-based care service shall contact the DMAS utilization review staff when the need for respite care as a secondary home and community-based care service has been identified according to the criteria above. DMAS shall conduct an assessment of the individual caregiver's need for respite care and, if appropriate, authorize respite care.

BOARD FOR OPTICIANS

Title of Regulation: **VR 505-01-01. Rules and Regulations of the Board of Opticians.** REPEALED

Title of Regulation: **VR 505-01-01:1. Board for Opticians Regulations.**

Statutory Authority: §§ 54.1-201 and 54.1-1705 of the Code of Virginia.

Public Hearing Date: May 15, 1991 - 9 a.m.
(See Calendar of Events section for additional information)

Summary:

The proposed regulations apply to approximately 1,135 licensed opticians who practice in the Commonwealth. These regulations are the result of implementing the regulatory review process which indicated a need to revise the current regulations. The regulations have been reorganized to provide clarity in the licensing procedure, including setting forth the qualifications of applicants, placing entry requirements before renewal, separating the procedures for renewal from those of reinstatement, the addition of information regarding fees for licensure, as well as the requirement that all applicants for licensure be in good standing if licensed in another jurisdiction and not have been convicted of a felony or misdemeanor in any jurisdiction.

VR 505-01-01:1. Board for Opticians Regulations.

PART I.
ENTRY.

§ 1.1. Qualifications of applicant.

A. Any person desiring to sit for examination shall submit an application on a form provided by the board with the required examination fee of $100. All fees are nonrefundable and shall not be prorated.

B. Each applicant shall provide evidence to the board that he:

1. Is at least 18 years of age;

2. Is a graduate of an accredited high school, or has completed the equivalent of grammar school and a four-year high school course, or is a holder of a certificate of general educational development;

3. Is in good standing as a licensed optician in every jurisdiction where licensed;

4. Has not been convicted in any jurisdiction of a misdemeanor involving moral turpitude, sexual offense, drug distribution or physical injury, or any felony. Any plea of nolo contendere shall be considered a conviction for purposes of this subdivision. The record of a conviction authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where convicted shall be admissible as prima facie evidence of such conviction; and

5. Has satisfactorily completed an approved two-year course in a school of opticianry, including the study of topics essential to qualify for practicing as an optician; or

6. Has completed a three-year apprenticeship with a minimum of one school year of related instruction or home study while registered in the apprenticeship program in accordance with the standards established by the State Department of Labor and Industry, Division of Apprenticeship Training and approved by the Virginia State Board for Opticians.

§ 1.2. Examination schedule.

The board shall schedule an examination to be held at least twice each calendar year at a time and place to be designated by the board. The examination application and fee must be received 60 calendar days prior to the written examination.

§ 1.3. Content of optician examination.

The optician examination given by the board will include the following topics:

1. Ophthalmic materials;

2. Ophthalmic optics and equipment;

3. Ophthalmic spectacle lens grinding;

4. Prescription interpretation;

5. Theory of light;

6. Finishing, fitting and adjusting of eyeglasses and frames;

7. Ethics of relationship in respect to patient and physician or optometrist;

8. Anatomy and physiology; and

9. Administrative duties.

§ 1.4. Passing grade and reexamination.

The passing grade shall be 70% on the written section and 70% on the practical section of the examination.

1. An applicant who fails any section shall be required to be reexamined on that section and shall pay the required reexamination fee of $75.

2. Any applicant who fails to pass the previously failed section within the next two successively scheduled examinations will be required to take and pass the entire examination and pay the full initial examination fee.

§ 1.5. Licensing of out-of-state opticians.

A. A licensed out-of-state optician seeking to be licensed as an optician in Virginia shall submit an application on a form provided by the board with the required fee of $100. All fees are nonrefundable and shall not be prorated.

B. The board, using the following standards, shall issue a license to any person who:

1. Has met requirements equivalent to those listed in § 1.1; and

2. Has passed a substantially equivalent examination.

§ 1.6. Endorsement to fit contact lenses; examination.

The board shall administer a contact lens examination to Virginia licensed opticians desiring to obtain an endorsement of "Contact Lens Competency" to fit contact lenses. The "Contact Lens Competency" endorsement shall be mandatory for opticians to fit contact lenses.

1. The applicant must achieve a passing score of 70% on the contact lens examination.

2. The fee for the contact lens examination or reexamination shall be $75. All fees are nonrefundable and shall not be prorated.

PART II.
RENEWAL/REINSTATEMENT.

§ 2.1. License renewal required.

A. Licenses issued under these regulations shall expire on December 31 of each even-numbered year. The Department of Commerce shall mail a renewal notice to the licensee outlining the procedures for renewal. Failure to receive this notice shall not relieve the licensee of the obligation to renew.

B. Each licensee applying for renewal shall return the renewal notice and fee of $75 to the Department of Commerce prior to the expiration date shown on the license. If the licensee fails to receive the renewal notice, a copy of the license may be submitted with the required fee.

C. Any licensee who fails to renew his license and desires to renew within one month after the license expires will be required to pay a late renewal fee which shall be equal to twice the regular renewal fee.

D. Applicants for renewal of a license shall continue to meet the standards for entry set forth in subdivisions B 3 and 4 of § 1.1. of these regulations.

E. The board may deny renewal of a license for the same reasons as it may refuse initial licensure.

§ 2.2. License reinstatement required.

A. If the licensee fails to renew his license after 30 days following the expiration date, he must apply for reinstatement of his license on a form provided by the board.

B. Additional fees for reinstatement are required as follows:

1. If the renewal fee is received by the department more than 30 days after the expiration date of the license, a reinstatement fee equal to twice the renewal fee is required.

2. If the reinstatement fee is received by the department more than 180 days after the expiration date of the license, a reinstatement fee equal to four times the renewal fee is required.

C. Applicants for reinstatement of a license shall continue to meet the standards for entry as set forth in subdivisions B 3 and 4 of § 1.1 of these regulations.

D. The board may deny reinstatement of a license for the same reasons as it may refuse initial licensure.

E. When an individual fails to renew his license after a period of one year after the expiration date, he must apply as follows:

1. Submit an application on a form provided by the board establishing that he has met all of the requirements of §§ 1.1 B 5 and 1.1 B 6 and a fee of $300;

2. The individual shall be required to take and receive a passing score of 70% on the practical examination and 70% on the written examination on his first attempt; and

3. If the applicant fails to pass both the written examination and the practical examination on his first attempt, he must meet the requirements of §§ 1.1 B 5 and 1.1 B 6 before sitting for the written examination and the practical examination again.

PART III.
STANDARDS OF PRACTICE.

§ 3.1. Display of license.

Every person to whom a current license has been granted under these regulations shall display it in public view.

§ 3.2. Notification of change of address or name.

A licensee shall notify the board in writing no later than 60 days after the occurrence of a change of address or name.

§ 3.3. Discipline.

The board may revoke, suspend, or refuse to renew a license, or impose a fine up to $1,000 per offense on a licensee for any of the following reasons:

1. Using alcohol or nonprescribed controlled substances as defined in Chapter 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia at the work place during working hours;

2. Displaying professional incompetence or negligence in the performance of opticianry;

3. Fraudulently certifying that an applicant possesses the qualifications required under § 1.1;

4. Violating or inducing others to violate any provisions of Chapters 1, 2, 3 or 17 of Title 54.1 of the Code of Virginia, or of any other statute applicable to the practice of the profession herein regulated, or of any provisions of these regulations;

5. Publishing or causing to be published any advertisement that is false, deceptive, or misleading;

6. Having been convicted in any jurisdiction of a misdemeanor involving moral turpitude, sexual offense, drug distribution or physical injury, or any felony. Any plea of nolo contendere shall be considered a conviction for the purposes of this section. The record of a conviction authenticated in such form as to be admissible in evidence under the laws of the jurisdiction where the conviction occurred shall be admissible as prima facie evidence of such conviction; or

7. Having been disciplined by another jurisdiction in the practice of opticianry.

DEPARTMENT OF COMMERCE
BOARD FOR OPTICIANS
P.O. Box 11066
RICHMOND, VIRGINIA 23230-1066
(804) 367-8534

PART I

TO BE COMPLETED BY ALL APPLICANTS

A. NAME_____
ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____
PHONE_____ DATE OF BIRTH_____
SOCIAL SECURITY NO.____ - ____ - ____

B. APPLICATION BY: EDUCATION_____ RECIPROCITY_____

C. **ATTACH FEE OF $100.00**
NOTE: DEPOSIT OF APPLICANT PROCESSING FEE DOES NOT INDICATE LICENSE HAS BEEN APPROVED. ALL FEES ARE NONREFUNDABLE. MAKE CHECK OR MONEY ORDER PAYABLE TO THE TREASURER OF VIRGINIA.

D. Have you ever pleaded guilty, entered a plea of nolo contendere or been convicted of a misdemeanor involving moral turpitude, sexual offense, drug distribution or physical injury, or any felony? ____YES ____NO

IF YES, explain_____

Attach appropriate documentation listed on instruction sheet.

E. Have you ever had a registration or license as an optician revoked, suspended, or subject to a disciplinary action (including probation, fine, reprimand or surrender) in any jurisdiction? ____YES ____NO

IF YES, explain_____

Attach appropriate documentation listed on instruction sheet.

F. ATTACH CERTIFICATION OF HIGH SCHOOL GRADUATION

PART II

A. COMPLETE THIS SECTION IF YOU ATTENDED A SCHOOL OF OPTICIANRY

Name and address of School of Opticianry attended:

_____

Date enrolled_____ Date completed_____
ATTACH CERTIFIED TRANSCRIPT

B. COMPLETE THIS SECTION IF YOU SERVED AN APPRENTICESHIP

Name and address of shop or shops in which you served a three year apprenticeship in accordance with the standards established by the Division of Apprenticeship Training of the Virginia Department of Labor and Industry as a Dispensing Optician.

_____

Date enrolled_____ Date completed_____
ATTACH "CHANGE OF STATUS" FORM

_____ _____
Signature of Apprenticeship Representative for the Department of Labor and Industry — Date

PART III.

USE THIS SECTION IF YOU ARE CURRENTLY REGISTERED/LICENSED IN ANOTHER STATE AS AN OPTICIAN

A. Complete Part I with appropriate documentation.

B. Complete applicable section of Part II with appropriate documentation.

C. Provide the following additional documentation:

1. Certification from your State Board that you have successfully passed an examination that is substantially equivalent to the examination given in VA.

2. A certification from your State Board that your license/registration is in good standing in that jurisdiction.

3. A copy of your current Optician license/registration.

PART IV.

TO BE COMPLETED BY ALL APPLICANTS

CERTIFICATION

I do hereby certify that I am the person making this application and that the information given by me on this application and attachments is true to the best of my knowledge and belief and is made for the express purpose of obtaining a license to practice opticianry in the Commonwealth of Virginia.

I am fully familiar with the fact that the Board for Opticians has the authority to revoke, or refuse to grant the license for which I have applied, if such licensure is obtained on the basis of any misrepresentation whatsoever.

_____ _____
Signature of Applicant — Date

STAFF USE ONLY PLEASE DO NOT WRITE BELOW THIS LINE

Approved for EXAMINATION____ Date of Exam_____

Approved for ENDORSEMENT____ State_____

Date of Exam	Practical Exam 1 2 3 4 5 6 Total	Written Exam	Remarks

INSTRUCTIONS FOR OBTAINING ADDITIONAL INFORMATION

IF YOU HAVE INDICATED YES TO QUESTIONS REGARDING A CRIMINAL CONVICTION OR FOR DISCIPLINARY ACTION TAKEN AGAINST YOU AS AN OPTICIAN, PLEASE SUPPLY THE APPROPRIATE ADDITIONAL INFORMATION.

LICENSE SUSPENDED, REVOKED, SURRENDERED OR OTHER DISCIPLINARY ACTION

If you have had a license which was suspended, revoked or surrendered in connection with a disciplinary action or a license which has been the subject of discipline in any jurisdiction including Virginia, please provide a brief explanation of the matter and certified true copies of documents which outline the details of the disciplinary action.

CONVICTION

If you have been convicted of a misdemeanor involving moral turpitude, sexual offense, drug distribution or physical injury or of any felony or have pleaded nolo contendere to any of the above, please supply the following information:

1. **Original FBI record.** If your conviction is outside of the Commonwealth of Virginia, provide copy of original FBI record.

To receive an original FBI record, obtain and complete a fingerprint card from your local police department. Attach a certified check for $14 to "U.S. Department of Treasury" with a request for a copy of your ID record from the FBI. In your request indicate the copy is for your own use. Send your request to the FBI, Identifications Division, 9th and Pennsylvania Avenue, N.W. Washington, D. C. 20537-9700.

2. **Original state police criminal history record.** If your conviction is in the Commonwealth of Virginia, provide original state police criminal history record.

To receive an original state police criminal history record, you must obtain and complete a criminal history record request form from your state police department. Virginia residents must complete the form in the presence of a notary public and mail it to the Department of State Police, Central Criminal Records Exchange, PO Box 27472, Midlothian, Virginia 23261-7472.

ALL APPLICANTS INDICATING A CRIMINAL CONVICTION MUST PROVIDE THE FOLLOWING DOCUMENTS.

3. Certified true copies of court papers.

To obtain certified true copies of all pertinent court papers, write to the Clerk of Court in that jurisdiction. The address is available from your local police department.

4. **Your written account.**

Your written account of the part you played at the time the offense occurred and the current status on resolution of final conviction charges relating to jail term, payment of fine, restitution, probation, etc.

PLEASE NOTE: APPLICANTS DISCLOSING CRIMINAL CONVICTIONS AND/OR LICENSE DISCIPLINARY ACTION MUST BE CONSIDERED SEPARATELY, THUS PROCESSING TIME FOR THE APPLICATION MAY BE LONGER. THESE APPLICATIONS WILL NOT BE REVIEWED UNTIL ALL APPLICABLE INFORMATION HAS BEEN RECEIVED.

COMMONWEALTH OF VIRGINIA
BOARD FOR OPTICIANS

P. O Box 11066
Richmond, Virginia 23230-1066
(804) 367-8534

APPLICATION FOR REINSTATEMENT OF VIRGINIA OPTICIAN LICENSE

PART I. APPLICANT INFORMATION

Date _____

TO BE COMPLETED BY ALL APPLICANTS

A. License No. _____

Date of expiration _____

B. Name _____

Address _____

City _____ State _____ Zip code _____

Phone ( ) _____

C. Have you ever pleaded guilty, entered a plea of nolo contendere or been convicted of a misdemeanor involving moral turpitude, sexual offense, drug distribution or physical injury, or any felony? ____YES ____NO

IF YES, explain _____

Attach appropriate documentation listed on instruction sheet.

D. Have you ever had a registration or license as an optician revoked, suspended, or subject to a disciplinary action (including probation, fine, reprimand or surrender) in any jurisdiction? ____YES ____NO

IF YES, explain _____

Attach appropriate documentation listed on instruction sheet.

PART II. REINSTATEMENT AFTER ONE YEAR

If you have failed to renew you license after a period of one (1) year, you must complete the appropriate section:

A. Provide the following information if you attended a School of Opticianry:

Name and address of School of Opticianry attended:

ATTACH CERTIFIED TRANSCRIPT

B. Provide the following information if you served an apprenticeship:

Name and address of shop or shops in which you served a three year apprenticeship in accordance with the standards established by the Division of Apprenticeship Training of the Virginia Department of Labor and Industry as a Dispensing Optician.

ATTACH "CHANGE OF STATUS" FORM

PART III. FEE INFORMATION

A. If reinstatement request is received by the Board 30 days after the expiration date of the license, a reinstatement fee of $ 150 is required.

B. If reinstatement request is received by the Board more than 180 days after the expiration date of the license, a reinstatement fee of $300 is required.

C. If the reinstatement request is received after one (1) year, a fee of $300 must be submitted.

MAKE CHECKS PAYABLE TO THE "TREASURER OF VIRGINIA". ALL FEES ARE NONREFUNDABLE. DEPOSIT OF APPLICANT PROCESSING FEE DOES NOT INDICATE LICENSE REINSTATEMENT HAS BEEN APPROVED.

PART IV.

TO BE COMPLETED BY ALL APPLICANTS

CERTIFICATION

I do hereby certify that I am the person making this application and that the information given by me on this application and attachments is true to the best of my knowledge and belief and is made for the express purpose of obtaining reinstatement of my Virginia Optician license.

I am fully familiar with the fact that the Board for Opticians has the authority to refuse to grant reinstatement of the license.

Signature of Applicant

Date

FOR STAFF USE ONLY

____ APPROVED ____ DISAPPROVED

_____ INITIALS DATE _____

INSTRUCTIONS FOR OBTAINING ADDITIONAL INFORMATION

IF YOU HAVE INDICATED YES TO QUESTIONS REGARDING A CRIMINAL CONVICTION OR FOR DISCIPLINARY ACTION TAKEN AGAINST YOU AS AN OPTICIAN, PLEASE SUPPLY THE APPROPRIATE ADDITIONAL INFORMATION.

LICENSE SUSPENDED, REVOKED, SURRENDERED OR OTHER DISCIPLINARY ACTION

If you have had a license which was suspended, revoked or surrendered in connection with a disciplinary action or a license which has been the subject of discipline in any jurisdiction including Virginia, please provide a brief explanation of the matter and certified true copies of documents which outline the details of the disciplinary action.

CONVICTION

If you have been convicted of a misdemeanor involving moral turpitude, sexual offense, drug distribution or physical injury or of any felony or have pleaded nolo contendere to any of the above, please supply the following information:

1. **Original FBI record.** If your conviction is outside of the Commonwealth of Virginia, provide copy of original FBI record.

To receive an original FBI record, obtain and complete a fingerprint card from your local police department. Attach a certified check for $14 to "U.S. Department of Treasury" with a request for a copy of your ID record from the FBI. In your request indicate the copy is for your own use. Send your request to the FBI, Identifications Division, 9th and Pennsylvania Avenue, N.W. Washington, D. C. 20537-9700.

2. **Original state police criminal history record.** If your conviction is in the Commonwealth of Virginia, provide original state police criminal history record.

To receive an original state police criminal history record, you must obtain and complete a criminal history record request form from your state police department. Virginia residents must complete the form in the presence of a notary public and mail it to the Department of State Police, Central Criminal Records Exchange, PO Box 27472, Midlothian, Virginia 23261-7472.

ALL APPLICANTS INDICATING A CRIMINAL CONVICTION MUST PROVIDE THE FOLLOWING DOCUMENTS.

3. **Certified true copies of court papers.**

To obtain certified true copies of all pertinent court papers, write to the Clerk of Court in that jurisdiction. The address is available from your local police department.

4. **Your written account.**

Your written account of the part you played at the time the offense occurred and the current status on resolution of final conviction charges relating to jail term, payment of fine, restitution, probation, etc.

PLEASE NOTE: APPLICANTS DISCLOSING CRIMINAL CONVICTIONS AND/OR LICENSE DISCIPLINARY ACTION MUST BE CONSIDERED SEPARATELY, THUS PROCESSING TIME FOR THE APPLICATION MAY BE LONGER. THESE APPLICATIONS WILL NOT BE REVIEWED UNTIL ALL APPLICABLE INFORMATION HAS BEEN RECEIVED.

BOARD FOR PROFESSIONAL SOIL SCIENTISTS

Title of Regulation: **VR 627-02-01. Board for Professional Soil Scientists Regulations.**

Statutory Authority: §§ 54.1-113 and 54.1-201 of the Code of Virginia.

Publication Date: 7:8 VA.R. 1212-1216 January 14, 1991.

NOTICE: The Department is WITHDRAWING the proposed regulation entitled "Board for Professional Soil Scientists Regulations" (VR 627-02-01) published in 7:8 VA.R. 1212-1216 January 14, 1991.

DEPARTMENT OF TAXATION

Title of Regulation: **VR 630-2-322.02. Individual Income Tax: Age Subtraction.**

Statutory Authority: § 58.1-203 of the Code of Virginia.

Publication Date: 7:1 VA.R. 35-39 October 8, 1990

NOTICE: The Department of Taxation is WITHDRAWING the regulation entitled "Individual Income Tax: Age Subtraction" (VR 630-2-322.02) published in 7:1 VA.R. 35-39 October 8, 1990.

For information concerning Final Regulations, see information page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates new text. Language which has been stricken indicates text to be deleted. [Bracketed language] indicates a substantial change from the proposed text of the regulations.

BOARD FOR GEOLOGY

Title of Regulation: **VR 335-01-2. Rules and Regulations for the Virginia Board for Geology.**

Statutory Authority: §§ 54.1-113 and 54.1-1402 of the Code of Virginia.

Effective Date: April 24, 1991.

NOTICE: As provided in § 9-6.14:22 of the Code of Virginia, this regulation is not being republished. It was adopted as it was proposed in 7:6 VA.R. 853-863 December 17, 1990.

DEPARTMENT OF HEALTH (STATE BOARD OF)

REGISTRAR'S NOTICE: This regulation is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 1 of the Code of Virginia, which excludes agency orders or regulations fixing rates or prices. The Department of Health will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **VR 355-39-01. Regulations Governing Eligibility Standards and Charges for Medical Care Services (Schedule of Charges Only).**

Statutory Authority: § 32.1-12 of the Code of Virginia.

Effective Date: April 25, 1991.

Summary:

This amendment will modify the Virginia Department of Health's schedule of charges so that charges for clinical services will be at maximum Medicaid reimbursement rates. Charges for three services will be increased. Two other services already provided will be more specifically identified and given charges so that Medicaid reimbursement for those services will be maximized.

STATE HEALTH DEPARTMENT
CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~JANUARY 1~~/ APRIL 25, 1991
EXCEPT FOR NORTHERN VIRGINIA - CHART I

By the provisions of the "Regulations Governing Eligibility Standards and Charges for Medical Care Services," promulgated by the authority of the Board of Health in accordance with § 32.1-12 of the Code of Virginia, listed below are the charges for medical care services, stating the minimum required payments to be made by patients toward their charges, according to income levels.

MEDICAL CARE SERVICES	MAXIMUM CHARGES[1] PER VISIT/SERVICE	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
A. MATERNITY/GYNECOLOGY[2]	~~$20/00~~	~~$//00~~	~~$/2/00~~	~~$/5/00~~	~~$10/00~~	~~$15/00~~	~~$20/00~~
	$25.75	$ .00	$ 2.50	$ 6.50	$12.75	$19.25	$25.75
Post-Partum Visit	$28.00	$ .00	$ 2.75	$ 7.00	$14.00	$21.00	$28.00
Maternity Care Coordination[14]							
1. Risk Screening	$10.00	$ .00	$ 1.00	$ 2.50	$ 5 00	$ 7.50	$10.00
2. Maternity Assessment	$25.00	$ .00	$ 2.50	$ 6.25	$12.5)	$18.75	$25.00
3. Maternity Follow-up	$40.00/month x 11 months	$ .00	$ 4.00	$10.00	$20.00	$30.00	$40.00
Nutrition Services							
1. Original Assessment	$20.00	$ .00	$ .00	$ .00	$ .00	$15.00	$20.00
2. Follow-up	$10.00/encounter	$ .00	$ .00	$ .00	$ .00	$ 7.50	$10.00
Group Education	$ 6.00 per class or session $36.00 maximum	$ .00	$ .60	$ 1.50	$ 3.00	$ 4.50	$ 6.00
Homemaker Services	$33.00 per visit or $ 8.00 per hour, not to exceed 4 hrs.	$ .00 $ .00	$ 3.30 $ .80	$ 8.25 $ 2.00	$16.50 $ 4.00	$24.75 $ 6.00	$33.00 $ 8.00
B. PEDIATRIC/WELL BABY							
~~I/ INITIAL/YEARLY~~							
1. New Patient, Comprehensive Visit	$37.00	$ .00	$ 3.75	$ 9.25	$18.50	$27.75	$37.00
2. Follow-up/Problem Visit	~~$20/00~~	~~$//00~~	~~$/2/00~~	~~$/5/00~~	~~$10/00~~	~~$15/00~~	~~$20/00~~
	$23.00	$ .00	$ 2.25	$ 5.75	$11.50	$17.25	$23.00
3. Established Patient, Comprehensive Visit	$36.75	$ .00	$ 3.50	$ 9.25	$18.25	$27.50	$36.75
Infant Care Coordination[14]							
1. Risk Screening	$10.00	$ .00	$ 1.00	$ 2.50	$ 5.00	$ 7.50	$10.00
2. Original Assessment	$25.00	$ .00	$ 2.50	$ 6.25	$12.50	$18.75	$25.00
3. Follow-up	$40.00/month x 24 months	$ .00	$ 4.00	$10.00	$20.00	$30.00	$40.00
C. FAMILY PLANNING[3]							
1. Initial/Annual Visit	$43.00	$ .00	$ 4.30	$10.75	$21.50	$32.25	$43.00
2. Follow-up/Problem	$20.00	$ .00	$ 2.00	$ 5.00	$10.00	$15.00	$20.00
D. GENERAL MEDICAL[4]							
~~I/ INITIAL/YEARLY~~							
1. New Patient, Comprehensive Visit	$37.00	$ .00	$ 3.75	$ 9.25	$18.50	$27.75	$37.00
2. Follow-up/Problem	~~$20/00~~	~~$//00~~	~~$/2/00~~	~~$/5/00~~	~~$10/00~~	~~$15/00~~	~~$20/00~~
	$23.00	$ .00	$ 2.25	$ 5.75	$11.50	$17.25	$23.00
3. Brief Visit	$15.00	$ .00	$ 1.50	$ 3.75	$ 7.50	$11.25	$15.00
4. Established Patient, Comprehensive Visit	$36.75	$ .00	$ 3.50	$ 9.25	$18.25	$27.50	$36.75
~~E/ BRIEF/SERVICE~~[5]	~~$/5/50~~	~~$//00~~	~~$/1/00~~	~~$/2/25~~	~~$/4/25~~	~~$/5/50~~	~~$/5/50~~
F. DENTAL[6]	MEDICAID RATE						
G. SPECIAL SERVICES[7] (WITHOUT ELIGIBILITY)							
1. Venipuncture	$ 7.00	----------FLAT RATE CHARGE[8]----------					
2. Pregnancy Testing	FREE	----------SERVICE PROVIDED FREE STATEWIDE----------					
3. Administration of Prescribed Medication and/or Nonroutine Immunizations PLUS: Cost of Vaccine when furnished by Health Department	$ 3.50	----------FLAT RATE CHARGE----------					
4. Blood Pressure Check	FREE	----------SERVICE PROVIDED FREE STATEWIDE----------					
5. PPD/Tuberculin Testing	$ 3.15	----------FLAT RATE CHARGE----------					
6. Radiological Examination	$18.00	----------FLAT RATE CHARGE----------					
7. Activities of Daily Living	$ 8.00	----------FLAT RATE CHARGE----------					
8. Cholesterol Screening and Counseling	$ 5.00	----------FLAT RATE CHARGE----------					
H. ELIGIBILITY REQUIRED							
1. Pharmacy Professional Fee PLUS: Cost of Drugs or Vaccine	$ 3.50	$ .00 0%	$ .50 10%	$ 1.00 25%	$ 1.75 50%	$ 2.75 75%	$ 3.50 100%
2. Other X-ray Services[10]	MEDICAID RATE						
3. Other Laboratory Services[11]	MEDICAID RATE						
4. Colposcopy Services							
a. Colpo With Biopsy	$86.00	$ .00	$ 8.75	$21.50	$43.00	$64.50	$86.00
b. Colpo With Biopsy and Cryosurgery	$105.00	$ .00	$10.50	$26.25	$52.50	$78.75	$105.00

EXCEPT FOR NORTHERN VIRGINIA - CHART I

MEDICAL CARE SERVICES	MAXIMUM CHARGES PER VISIT/SERVICE	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
I. OTHER SERVICES							
1. Children's Specialty Services (Annual)	$120.00	$ .00	$12.00	$30.00	$60.00	$90.00	$120.00
J. CHILD DEVELOPMENT SERVICES (according to Physicians' Current Procedural Terminology)							
1. Medical Services							
Limited, new patient	$22.00	$ .00	$ 2.20	$ 5.50	$11.00	$16.50	$22.00
est. patient	$17.00	$ .00	$ 1.70	$ 4.25	$ 8.50	$12.75	$17.00
Intermediate, new	$23.00	$ .00	$ 2.30	$ 5.75	$11.50	$17.25	$23.00
est.	$19.00	$ .00	$ 1.90	$ 4.75	$ 9.50	$14.25	$19.00
Comprehensive, new	$37.00	$ .00	$ 3.70	$ 9.25	$18.50	$27.75	$37.00
est.	$20.00	$ .00	$ 2.00	$ 5.00	$10.00	$15.00	$20.00
Initial Consultation, Interm.	$21.00	$ .00	$ 2.10	$ 5.25	$10.50	$15.75	$21.00
Follow-up Consultation, Interm.	$10.50	$ .00	$ 1.05	$ 2.65	$ 5.25	$ 7.90	$10.50
Pharmocological Management	$ 8.50	$ .00	$ .85	$ 2.10	$ 4.25	$ 6.35	$ 8.50
Developmental Screening	$ 8.50	$ .00	$ .85	$ 2.10	$ 4.25	$ 6.35	$ 8.50
Health Education	$10.50	$ .00	$ 1.05	$ 2.65	$ 5.25	$ 7.90	$10.50
2. Mental Health Services							
Psychological Evaluation per hr.	$105.00	$ .00	$10.50	$26.25	$52.50	$78.75	$105.00
Psycho-social Assessment	$30.00	$ .00	$ 3.00	$ 7.50	$15.00	$22.50	$30.00
Individual Psychotherapy per 1/2 hour	$15.75	$ .00	$ 1.60	$ 3.95	$ 7.90	$11.85	$15.75
Family Psychotherapy	$10.50	$ .00	$ 1.05	$ 2.65	$ 5.25	$ 7.90	$10.50
Group Psychotherapy	$10.50	$ .00	$ 1.05	$ 2.65	$ 5.25	$ 7.90	$10.50
Multifamily Psychotherapy	$10.50	$ .00	$ 1.05	$ 2.65	$ 5.25	$ 7.90	$10.50
3. Educational Services							
Educational Diagnostic Evaluation	-NC-		SERVICE PROVIDED FREE STATEWIDE				
School Visit/Consultation	-NC-		SERVICE PROVIDED FREE STATEWIDE				
Classroom Observation	-NC-		SERVICE PROVIDED FREE STATEWIDE				
4. Case Management Services							
Interdisciplinary Medical Conference	$26.00	$ .00	$ 2.60	$ 6.50	$13.00	$19.50	$26.00
Medical Conference with Patient and/or Family	$27.00	$ .00	$ 2.70	$ 6.75	$13.50	$20.25	$27.00
Other Case Management Activity	-NC-		SERVICE PROVIDED FREE STATEWIDE				
Progress Review	-NC-		SERVICE PROVIDED FREE STATEWIDE				

STATE HEALTH DEPARTMENT
CHARGES AND PAYMENT REQUIREMENTS BY INCOME LEVELS
EFFECTIVE ~~JANUARY 1~~/APRIL 25, 1991

NORTHERN VIRGINIA - CHART II

By the provisions of the "Regulations Governing Eligibility Standards and Charges for Medical Care Services," promulgated by the authority of the Board of Health in accordance with § 32.1-12 of the Code of Virginia, listed below are the charges for medical care services, stating the minimum required payments to be made by patients toward their charges, according to income levels.

MEDICAL CARE SERVICES	MAXIMUM CHARGES PER VISIT/SERVICE	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
MATERNITY/GYNECOLOGY(2)	~~$22.75~~	~~$1.00~~	~~$2.25~~	~~$5.75~~	~~$11.25~~	~~$17.00~~	~~$22.75~~
	$29.25	$ .00	$ 3.00	$ 7.25	$14.50	$21.75	$29.25
POST-PARTUM VISIT	$32.00	$ .00	$ 3.25	$ 8.00	$16.00	$24.00	$32.00
MATERNITY CARE COORDINATION(14)							
1. RISK SCREENING	$11.50	$ .00	$1.25	$ 3.00	$ 5.75	$ 8.75	$11.50
2. MATERNITY ASSESSMENT	$28.50	$ .00	$2.85	$ 7.25	$14.25	$21.50	$28.50
3. MATERNITY FOLLOW-UP	$45.50/MO. x 11 MONTHS	$ .00	$4.55	$11.50	$22.75	$34.25	$45.50
NUTRITION SERVICES							
1. ORIGINAL ASSESSMENT	$22.75	$ .00	$2.50	$ 5.75	$11.50	$17.00	$22.75
2. FOLLOW-UP	$11.50/ENCOUNTER	$ .00	$1.25	$ 3.00	$ 5.75	$ 8.75	$11.50
GROUP EDUCATION	$ 7.00 PER CLASS/SESSION $41.00 MAXIMUM	$ .00	$ .75	$ 1.75	$ 3.50	$ 5.25	$ 7.00
HOMEMAKER SERVICES	$37.50 PER VISIT OR $ 9.25 PER HOUR, NOT TO EXCEED 4 HOURS	$ .00 $ .00	$ 3.75 $ .95	$ 9.50 $ 1.85	$18.75 $ 4.75	$28.25 $ 6.95	$37.50 $ 9.25
PEDIATRIC/WELL BABY							
~~INITIAL/YEARLY~~							
NEW PATIENT, COMPREHENSIVE EXAM	$42.00	$ .00	$ 4.20	$10.50	$21.00	$31.50	$42.00
FOLLOW-UP/PROBLEM VISIT	~~$22.75~~	~~$1.00~~	~~$2.50~~	~~$5.75~~	~~$11.50~~	~~$17.00~~	~~$22.75~~
	$26.25	$ .00	$ 2.50	$ 6.50	$13.00	$19.50	$26.25
ESTABLISHED PATIENT, COMPREHENSIVE EXAM	$42.00	$ .00	$ 4.25	$10.50	$21.00	$31.50	$42.00
INFANT CARE COORDINATION(14)							
1. RISK SCREENING**	$11.50	$ .00	$1.85	$ 3.00	$ 5.75	$ 8.75	$11.50
2. ORIGINAL ASSESSMENT	$28.50	$ .00	$ 2.85	$ 7.25	$14.25	$21.50	$28.50
3. FOLLOW-UP**	$45.00 PER MONTH x 24 MONTHS	$ .00	$ 4.60	$11.25	$22.55	$33.75	$45.00

NORTHERN VIRGINIA - CHART II

MEDICAL CARE SERVICES	MAXIMUM CHARGES PER VISIT/SERVICE	INCOME LEVEL A (0%)	INCOME LEVEL B (10%)	INCOME LEVEL C (25%)	INCOME LEVEL D (50%)	INCOME LEVEL E (75%)	INCOME LEVEL F (100%)
FAMILY PLANNING[3]							
INITIAL/ANNUAL VISIT	$48.75	$ .00	$ 4.75	$12.25	$24.50	$36.50	$48.75
FOLLOW-UP/PROBLEM VISIT	$22.75	$ .00	$ 2.25	$ 5.75	$11.25	$17.00	$22.75
GENERAL MEDICAL[4]							
INITIAL/VISIT							
NEW PATIENT, COMPREHENSIVE VISIT	$42.00	$ .00	$ 4.25	$10.50	$21.00	$31.50	$42.00
FOLLOW-UP/PROBLEM VISIT	$22.75	$ .00	$ 2.25	$ 5.75	$11.25	$17.00	$22.75
BRIEF VISIT	$17.00	$ .00	$ 1.75	$ 4.25	$ 8.50	$12.75	$17.00
ESTABLISHED PATIENT, COMPREHENSIVE VISIT	$42.00	$ .00	$ 4.25	$10.50	$21.00	$31.50	$42.00
BRIEF/SERVICE[5]	$ 9.75	$ .00	$ 1.00	$ 2.50	$ 4.75	$ 7.25	$ 9.75
DENTAL[6]	MEDICAID RATE						
SPECIAL SERVICES[7] WITHOUT ELIGIBILITY							
VENIPUNCTURE	$ 8.00	FLAT RATE CHARGE[8]					
PREGNANCY TESTING	FREE	SERVICE PROVIDED FREE STATEWIDE					
ADMIN OF PRESC MED/NONROUTINE IMM (PLUS COST OF VACCINE WHEN FURNISHED BY HEALTH DEPT)	$ 4.00	FLAT RATE CHARGE					
BLOOD PRESSURE CHECK	FREE	SERVICE PROVIDED FREE STATEWIDE					
PPD/TUBERCULIN TESTING	$ 3.55	FLAT RATE CHARGE					
RADIOLOGICAL EXAM (CHEST)	$20.50	FLAT RATE CHARGE					
ACTIVITIES OF DAILY LIVING (PER HR)	$ 9.00	FLAT RATE CHARGE					
CHOLESTEROL SCREENING AND COUNSELING	$ 6.00	FLAT RATE CHARGE					
ELIGIBILITY REQUIRED							
PHARMACY PROFESSIONAL FEE (PLUS COST OF DRUGS OR VACCINE)	$ 4.00	$ .00	$ .50	$ 1.00	$ 2.00	$ 3.00	$ 4.00
OTHER X-RAY SERVICES[10]	MEDICAID RATE						
OTHER LAB SERVICES[11]	MEDICAID RATE						
COLPOSCOPY SERVICES							
COLPO WITH BIOPSY	$97.50	$ .00	$ 9.75	$24.50	$48.75	$73.25	$97.50
COLPO WITH BIOPSY AND CYROSURGERY	$119.25	$ .00	$12.00	$29.75	$59.50	$89.50	$119.25
OTHER SERVICES							
CHILD SPECIALTY SERVICES (ANNUAL)	$136.00	$ .00	$13.50	$34.00	$68.00	$102.00	$136.00
CHILD DEVELOPMENT SERVICES (according to Physicians' Current Procedural Terminology)							
Medical Services							
Limited, new patient	$25.00	$ .00	$ 2.50	$ 6.25	$12.50	$18.75	$25.00
est. patient	$19.30	$ .00	$ 1.95	$ 4.85	$ 9.65	$14.50	$19.30
Intermediate, new patient	$26.00	$ .00	$ 2.60	$ 6.50	$13.00	$19.50	$26.00
est. patient	$21.60	$ .00	$ 2.15	$ 5.40	$10.80	$16.20	$21.60
Comprehensive, new patient	$42.00	$ .00	$ 4.20	$10.50	$21.00	$31.50	$42.00
est. patient	$22.75	$ .00	$ 2.50	$ 5.75	$11.50	$17.00	$22.75
Initial Consultation, Interm.	$24.00	$ .00	$ 2.40	$ 6.00	$12.00	$18.00	$24.00
Follow-up Consultation, Interm.	$12.00	$ .00	$ 1.20	$ 3.00	$ 6.00	$ 9.00	$12.00
Pharmocological Management	$ 9.50	$ .00	$ .95	$ 2.40	$ 4.75	$ 7.15	$ 9.50
Developmental Screening	$ 9.50	$ .00	$ .95	$ 2.40	$ 4.75	$ 7.15	$ 9.50
Health Education	$12.00	$ .00	$ 1.20	$ 3.00	$ 6.00	$ 9.00	$12.00
Mental Health Services							
Psychological Evaluation per hr.	$120.00	$ .00	$12.00	$30.00	$60.00	$90.00	$120.00
Psycho-social Assessment	$34.00	$ .00	$ 3.40	$ 8.50	$17.00	$25.50	$34.00
Individual Psychotherapy per 1/2 hour	$18.00	$ .00	$ 1.80	$ 4.50	$ 9.00	$13.50	$18.00
Family Psychotherapy	$12.00	$ .00	$ 1.20	$ 3.00	$ 6.00	$ 9.00	$12.00
Group Psychotherapy	$12.00	$ .00	$ 1.20	$ 3.00	$ 6.00	$ 9.00	$12.00
Multifamily Psychotherapy	$12.00	$ .00	$ 1.20	$ 3.00	$ 6.00	$ 9.00	$12.00
Educational Services							
Educational Diagnostic Evaluation	-NC-	SERVICE PROVIDED FREE STATEWIDE					
School Visit/Consultation	-NC-	SERVICE PROVIDED FREE STATEWIDE					
Classroom Observation	-NC-	SERVICE PROVIDED FREE STATEWIDE					
Case Management Services							
Interdisciplinary Medical Conference	$29.50	$ .00	$ 2.95	$ 7.35	$14.75	$22.10	$29.50
Medical Conference with Patient and/or Family	$30.50	$ .00	$ 3.05	$ 7.65	$15.25	$22.90	$30.50
Other Case Management Activity	-NC-	SERVICE PROVIDED FREE STATEWIDE					
Progress Review	-NC-	SERVICE PROVIDED FREE STATEWIDE					

ALL FOOTNOTES FOR STATEWIDE CHARGES STILL APPLY TO NORTHERN VIRGINIA CHARGES

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

Title of Regulation: **VR 615-01-34. Aid to Dependent Children - Unemployed Parent (ADC-UP) Program.**

Statutory Authority: § 63.1-25 of the Code of Virginia.

Effective Date: October 1, 1991.

Summary:

According to the Family Support Act of 1988, Public Law 100-485, states are mandated to implement the Aid to Dependent Children - Unemployed Parent (ADC-UP) Program. All categorical requirements and conditions of eligibility are the same as for the ADC Program unless otherwise specified except that deprivation of a child is due to the unemployment of the principal wage earner parent and the dependent child must be living in a residence where both natural or adoptive parents are residing. The regulation set forth herein assures compliance with federal regulations and laws by implementing the ADC-UP Program for two parent unemployed families.

When an ADC-UP case is approved, benefits are limited to six months in a 12-consecutive-month period for unemployed two-parent families who are in need.

VR 615-01-34. Aid to Dependent Children - Unemployed Parent (ADC-UP) Program.

PART I.
DEFINITIONS.

§ 1.1. The following words and terms, when used in these guidelines, shall have the following meaning unless the context clearly indicates otherwise:

"Aid to Dependent Children-Unemployed Parent (ADC-UP) Program" means the program [~~*which will be*~~] *administered by the Virginia Department of Social Services* [~~*effective October 1, 1990,*~~] *which* [~~*will provide*~~ *provides*] *financial assistance to needy two-parent unemployed families.*

"Application for assistance" means the date of receipt of a signed, completed application requesting assistance.

"Assistance unit" means those persons whose needs and income shall be considered in the determination of eligibility for assistance.

"Attachment to the workforce" means the principal wage earner parent received unemployment compensation benefits under an unemployment compensation law of Virginia or of the United States or would have qualified for unemployment compensation under Virginia's Unemployment Compensation Act, or had employment in six or more calendar quarters of work within a 13-consecutive-calendar-quarter period ending within one year of application for assistance.

"Bona fide offer of employment or training" means that there was a definite offer of employment actually made.

"Dependent child" means any child of an unemployed parent, who would be eligible under the Aid to Dependent Children (ADC) Program except for the fact that his parent is not dead, absent from the home, or incapacitated. The child must be living in a place of residence with both natural or adoptive parents.

"Employment Services Program" means a program operated by the Department of Social Services which helps ADC-UP recipients in securing employment or the training or education needed to secure employment.

"Good cause" means the factors which must be considered, such as the capacity of the principal wage earner parent to do the work; the location of the employment and whether transportation is needed and available; applicable minimum wage requirements and customary wages paid for comparable work in the community; or working conditions, such as risks to health and safety or lack of workers' compensation protection.

"Principal wage earner" means the parent in the home who earned the greater amount of income in the 24-month period, the last month of which immediately precedes the month in which an application is filed for assistance.

"Qualified for unemployment compensation" means that the principal wage earner parent would have been eligible to receive benefits had he applied, based on wages covered under the Unemployment Compensation Act of Virginia, wages not covered under the Unemployment Compensation Act of Virginia, or a combination of both.

"Quarter of work" means a period of three consecutive calendar months ending March 31, June 30, September 30, or December 31 in which the principal wage earner parent earned at least $50 or participated in the Employment Services Program (ESP).

"Sibling" means two or more children with at least one natural or adoptive parent in common.

"Unemployed" means employed less than 100 hours a month; or exceeds that standard for a particular month if his work is intermittent and the excess is of a temporary nature as evidenced by the fact that he was under the 100-hour standard for two prior months and is expected to be under the standard during the next month.

PART II.
HOUSEHOLD COMPOSITION.

§ 2.1. Aid to Dependent Children - Unemployed Parent (ADC-UP) Program is limited to those families with a dependent child who is residing with both natural or adoptive parents, who would be eligible for assistance

through the Aid to Dependent Children (ADC) Program except that he is not deprived due to the continued absence, death or incapacity of at least one parent, but due to the unemployment of the parent.

§ 2.2. Any sibling of a child who is deprived based on the unemployment of a parent, who is himself deprived based on the continued absence or death of a parent will be included in the ADC-UP assistance unit.

PART III.
DEPRIVATION.

§ 3.1. The dependent child is deprived due to the unemployment of the principal wage earner parent. The principal wage earner parent is that parent who earned the greater amount of income in the 24-month period, the last month of which immediately precedes the month in which an application is filed for assistance and the principal wage earner parent:

1. Has been unemployed for at least 30 days prior to receipt of assistance, and

2. Has not without good cause, within such 30-day period prior to receipt of assistance, refused a bona fide offer of employment or training, and

3. Has an attachment to the work force as evidenced by receipt of unemployment compensation benefits or would have qualified for unemployment compensation benefits within one year prior to application for assistance, or had six quarters of work within a 13-consecutive-calendar-quarter period ending within one year of application for assistance, and

4. Has not refused to apply for or accept unemployment compensation which he qualified for under the Unemployment Compensation Act of Virginia or of the United States.

PART IV.
FINANCIAL ELIGIBILITY.

§ 4.1. Unemployment compensation received by a principal wage earner parent shall be considered only by subtracting it from the amount of the assistance payment after the payment has been determined under the Commonwealth's payment method.

PART V.
EMPLOYMENT SERVICES.

§ 5.1. In addition to sanctioning a parent who fails or refuses to participate in the Employment Services Program (ESP), the needs of the other parent will also not be taken into account in determining the family's eligibility and the amount of assistance if the other parent is not participating in ESP.

PART VI.
DATE OF ENTITLEMENT.

§ 6.1. The date of entitlement shall not begin before the principal wage earner parent has been unemployed for at least 30 days.

PART VII.
LIMITATION OF ASSISTANCE.

§ 7.1. In the ADC-UP Program, assistance for cash benefits is limited to six months in a 12-consecutive-month period. The 12-consecutive-month period begins in the first month of eligibility

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: **VR 460-02-4.1930. Elimination of Medicaid Payment for Reserving Nursing Facility Beds for Hospitalized Patients.**

Statutory Authority: § 32.1-325 of the Code of Virginia.

Effective Dates: March 1, 1991, through February 29, 1992.

Summary:

1. REQUEST: The Governor's approval is hereby requested to adopt the emergency regulations entitled Elimination of Medicaid Payment for Reserving a Nursing Facility Bed for Hospitalized Residents.

2. RECOMMENDATION: Recommend approval of the Department's request to take an emergency adoption action regarding elimination of Medicaid Payment for Reserving a Nursing Facility Bed for Hospitalized Residents. The Department intends to initiate the public notice and comment requirements contained in the Code of Virginia § 9-6.14:7.1.

/s/ Bruce U. Kozlowski
Director
Date: February 12, 1991

3. CONCURRENCES:

/s/ Howard M. Cullum
Secretary of Health and Human Resources
Date: February 20, 1991

4. GOVERNOR'S ACTION:

/s/ Lawrence Douglas Wilder
Governor
Date: February 25, 1991

5. FILED WITH:

/s/ Joan W. Smith
Registrar of Regulations
Date: February 26, 1991

DISCUSSION

6. BACKGROUND: The purpose of this action is to amend the Plan for Medical Assistance to eliminate Medicaid payment for reserving a bed in a nursing facility for a resident during periods when that resident is hospitalized. The section of the State Plan affected by this action is Attachment 3.1 C (VR 460-02-3.1300). This regulation is responsive to the Administration's directive to identify potential cost savings initiatives.

On July 1, 1982 Virginia Medicaid policy was changed to terminate the practice of paying nursing facilities for reserving the beds of nursing facility residents during their hospitalization. As an integral part of this policy, facilities were required to ensure that a former resident discharged from a hospital was given the opportunity to be readmitted to that facility at the time of the next available vacancy.

Effective July 1, 1988, Virginia Medicaid policy was changed to provide for Medicaid payment to nursing facilities in a planning district whose occupancy rate was 96% or better, in order to hold a nursing home bed for up to 12 days for a hospitalized resident. The policy was instituted to ensure more timely discharge of residents from acute care hospitals; in fact, it had the opposite effect. A study of hospital lengths of stay for nursing home residents showed that those residents not covered by the bed hold policy were discharged from the hospital on average one day sooner than those covered by the policy. The average length of stay in planning districts with bed hold days was 9.32 days, while the length of stay in planning districts without bed hold days was 8.62 days (1990 claims data). This may be attributed in part to the fact that when families were paying private rates to hold the bed, they may have communicated more often with the hospital physician and pushed for an early discharge. Another phenomenon reported to DMAS that occurred concurrent with this new policy was that hospitals were not always able to discharge first-time admissions to nursing facilities because beds were being held.

The Department does not anticipate that eliminating this coverage policy will cause nursing facility residents to be displaced. When the policy of reserving nursing facility beds for hospitalized residents was eliminated in 1982, DMAS monitored closely the outcomes for hospitalized residents in three ways: first, it checked facility compliance as part of its inspection of care activities; second, it investigated charges of non-compliance; and third, it conducted a six-year long telephone survey of policy results. Only 1-2% of all hospitalized residents were displaced to another nursing facility, but all who wanted to return to their original facility later did so.

7. AUTHORITY TO ACT: The Code of Virginia (1950) as amended, § 32.1-324, grants to the Director of the Department of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:9, for this agency's adoption of emergency regulations subject to the Governor's approval. Subsequent to the emergency adoption action and filing with the Registrar of Regulations, the Code requires this agency to initiate the public notice and comment process as contained in Article 2 of the APA.

The Code of Federal Regulations § 447.40 provides for the Department's optional payment to reserve a bed during a recipient's temporary absence from an inpatient facility.

Without an emergency regulation, this amendment to the State Plan cannot become effective until the publication and concurrent comment and review period requirements of the APA's Article 2 are met. Therefore, an emergency regulation is needed to meet the March 1, 1991, effective date in support of the Administration's cost saving requirements.

8. FISCAL/BUDGETARY IMPACT: There are 22 planning districts in the State. Based on the occupancy rates obtained from nursing facilities' cost reports filed with DMAS, 14 districts (1, 2, 4, 5, 6, 7, 11, 12, 13, 14, 15, 16, 17, 22) had facilities with an occupancy rate of 96% or above at the time of the most recent cost report filed as of June 30, 1990. Therefore, for fiscal year 1991, 104 of the 227 nursing facilities statewide, are in planning districts that have bed hold day reimbursement.

In FY 1990, there were 3,720 acute hospitalizations of nursing facility residents. Of this total, 29% were from planning districts that did not have bed hold coverage, and 71% from those who did. Of the planning districts that were covered by bed hold days, Medicaid funds paid for 20,297 bed hold days. Based on an average nursing facility reimbursement rate of $60 per day, this resulted in $1,219.068 ($600,000 NGF; $600,000 GF) reimbursement to the facilities.

9. RECOMMENDATION: Recommend approval of this request to take an emergency adoption action to become effective March 1, 1991. From its effective date, this regulation is to remain in force for one full year or until superseded by final regulations promulgated through the APA. Without an effective emergency regulation, the Department would lack the authority to discontinue payments for nursing facility beds when the resident is hospitalized.

10. Approval Sought for VR 460-02-4.1930. Approval of the Governor is sought for an emergency modification of the Medicaid State Plan in accordance with the Code of Virginia § 9-6.14:4.1(C)(5) to adopt the following regulation:

VR 460-02-4.1930. Elimination of Medicaid Payment for Reserving Nursing Facility Beds for Hospitalized Patients.

§ 1. Payment is made for reserving beds in long-term care facilities for recipients during their temporary absence for the following purpose:

A. For leaves of absence up to eighteen (18) days per year for any reason other than inpatient hospital admissions.

~~B. For up to 12 reserve bed days per admission when a nursing home patient requires hospitalization and the nursing home is in a planning district in which the average occupancy for all licensed and certified nursing homes is more than 96% based on a 12 month average of the occupancy reported in Medicaid nursing home cost reports filed with the Department of Medical Assistance Services as of June 30 of each year. Such reserve bed days will be applicable to hospital stays beginning on or after July 1, 1988. Payment will be made prospectively to eligible nursing homes which are licensed, certified and have a valid provider agreement as of July 1 of each year. The Department of Medical Assistance Services will notify eligible nursing homes that they may bill for up to the 12 reserve bed days for the year beginning each July 1 through June 30. Families may not be billed to reserve bed days for which the Department of Medical Assistance Services will allow payment.~~

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (BOARD OF)

Title of Regulation: **VR 470-05-02. Emergency Regulation for Certification of Therapeutic Consultation and Residential Services.**

Statutory Authority: §§ 37.1-10 and 37.1-179 of the Code of Virginia and Item 466.F.5 of the 1990 Appropriations Act.

Effective Dates: March 5, 1991 through March 4, 1992.

Summary:

1. REQUEST: The Governor's approval is hereby requested to adopt the emergency regulation entitled Certification of Therapeutic Consultation and Residential Support Services. These regulations will enable the implementation of a certification system which will allow Title XIX payments, with 50% federal financial participation, for services previously reimbursed with 100% state dollars.

2. RECOMMENDATION: Recommend approval of the Department's request to take an emergency adoption action regarding these regulations. The Department intends to initiate the public notice and comment requirements contained in the Code of Virginia § 9-6.14:7.1.

/s/ King E. Davis, Ph.D.
Commissioner
Date: December 21, 1990

3. CONCURRENCES:

/s/ Howard M. Cullum
Secretary of Health and Human Resources
Date: December 27, 1990

4. GOVERNOR'S ACTION:

/s/ Lawrence Douglas Wilder
Governor
Date: February 21, 1991

5. FILED WITH:

/s/ Joan W. Smith
Registrar of Regulations
Date: March 5, 1991

DISCUSSION

6. BACKGROUND: The 1990 Appropriations Act also directed DMAS with the assistance of DMHMRSAS (Item 478) to develop a homebased and community-based waiver under Section 1915(c) of the Social Security Act. This waiver is designed to provide community-based alternatives to persons who would otherwise require placement in a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). It is intended to reduce the need for institutional placement.

Under the terms of this waiver, assurances must be made that services are provided by qualified individuals. In order to make these assurances, DMHMRSAS is promulgating regulations which require that if services are going to be reimbursed by DMAS, the persons providing the services must meet certain standards. For therapeutic consultation, the individual must meet the following standards:

1. Psychologists shall be licensed by the Department of Health Professions.

2. Occupational therapists shall be certified by the Department of Health Professions.

3. Physical therapists shall be licensed by the Department of Health Professions.

4. Speech Therapists shall be licensed by the Department of Health Professions.

5. Social Workers shall be licensed by the Department of Health Professions.

6. Behavioral therapy consultation must be provided by individuals who meet the knowledge, skills and abilities established by DMHMRSAS.

For residential support services provided under the waiver, the individual must pass an objective test of skills, knowledge and abilities approved by DMHMRSAS.

7. AUTHORITY TO ACT: The Code of Virginia § 37.1-10 gives the State Mental Health, Mental Retardation and Substance Abuse Services Board the authority to promulgate regulations to carry out the provisions of the laws of the Commonwealth. The Code in § 37.1-179 et seq gives the Commissioner the authority to license facilities and institutions. Item 466.F.5 of the 1990 Appropriations Act states that qualified providers shall be licensed or certified under regulations promulgated by DMHMRSAS. Item 478.F.1 states that DMAS and DMHMRSAS shall submit a home-based and community-based waiver under Section 1915(c) of the Social Security Act.

Without an emergency regulation, certification of services cannot become effective until the publication and concurrent comment and review period requirements of the APA's Article 2 are met. Due to the substantial program development activities necessary to implement these new services, it was not possible to meet the time schedule of the APA public comment requirements. Therefore, an emergency regulation is needed to meet the January 1, 1991 date for the commencement of the waiver services.

8. FISCAL/BUDGETARY IMPACT: This initiative is not expected to result in any new General Fund expenditures by DMHMRSAS. The General Funds necessary to draw down the Federal matching dollars will be transferred by DMHMRSAS to DMAS from funds appropriated for the 1990-92 Biennium.

9. RECOMMENDATION: Recommend approval of this request to take an emergency adoption action to become effective January 1, 1991. From its effective date, this regulation is to remain in force for one full year or until superseded by final regulations promulgated through the APA. Without an effective emergency regulation, DMHMRSAS could not make the quality assurances necessary for the home-based and community-based waiver.

10. APPROVAL SOUGHT FOR VR 470-05-02: Approval of the Governor is sought for the adoption of the attached emergency regulations in accordance with Code of Virginia § 9-6.14:4.1(C)(5).

VR 470-05-02. Emergency Regulation for Certification of Therapeutic Consultation and Residential Services.

PART I.
INTRODUCTION.

Article 1.
Definitions.

§ 1.1 Definitions.

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

"Board" means the State Mental Health, Mental Retardation and Substance Abuse Services Board.

"Commissioner" means the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services.

"Department" means the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"Individual" means any person who provides Therapeutic Consultation or Residential Support Services to waiver recipients.

"Facility" means any facility not operated by an agency of the federal government by whatever name or designation which provides Therapeutic Consultation or Residential Support Services to waiver recipients. Such institution or facility shall include a hospital as defined in subsection 1 of § 32.1-123 of the Code of Virginia, outpatient clinic, special school, halfway house, home and any other similar or related facility.

"Mental Retardation" means substantial subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behavior.

"Residential Support" means services provided to the waiver recipient in the individual's home, in a residence licensed by the Department or by the Department of Social Services or in an adult foster care home approved by a local Department of Social Services. These services include training, assistance and supervision provided in order to:

1. maintain the individual's health;

2. assist in self care tasks;

3. train in daily living activities; and

4. assist in adapting to a community environment.

"Therapeutic Consultation" means activities under a mental retardation waiver which assist parents/family members, residential support and day support providers in implementing an individual program plan.

"Waiver" means mental retardation services provided under Sections 1915(c), 1902(a) (10)B, and 1902(a)(10)(c)(iii) of the Social Security Act.

Article 2.
Legal Base.

§ 1.2. Pursuant to § 37.1-10 the Board shall make, adopt and promulgate such rules and regulations as may be necessary to carry out the provisions of laws of the Commonwealth administered by the Commissioner or the Department. Section 37.1-179 et seq. requires facilities providing care and treatment of mentally ill, mentally retarded and substance abusing persons to be licensed in accordance with regulations promulgated by the Board. Item 466.F.5 of the 1990 Appropriations Act requires that qualified providers shall be licensed or certified under regulations promulgated by the Department.

Article 3.
Services Subject to Certification Under These Regulations.

§ 1.3. No person shall establish, conduct, maintain or operate in this Commonwealth therapeutic consultation or residential support services which receive reimbursement from the Department of Medical Assistance Services without first being duly certified except where such services are exempt from certification.

Article 4.
Application for Therapeutic Consultation and Residential Support Certification.

§ 1.4. A facility or individual desiring to be certified or recertified for residential support services provided to waiver recipients for which reimbursement from the Department of Medical Assistance Services will be sought shall submit a letter to the Commissioner requesting certification. This letter shall constitute the application for certification and shall state the individuals providing these services have passed an objective test of knowledge, skills and abilities approved by the Department.

§ 1.5. A facility or individual desiring to be certified or recertified for therapeutic consultation services shall submit to the Commissioner a letter stating that individuals providing the services for which reimbursement from the Department of Medical Assistance Services will be sought meet the following standards:

1. Psychologist shall be licensed by the Department of Health Professions.

2. Occupational therapists shall be certified by the Department of Health Professions.

3. Physical therapists shall be licensed by the Department of Health Professions.

4. Speech Therapists shall be licensed by the Department of Health Professions.

5. Social Workers shall be licensed by the Department of Health Professions.

6. Behavioral therapy consultation must be provided by individuals who are endorsed by the Department as meeting the knowledge, skills and abilities as established by the Department and attached hereto.

Article 5
The Certification.

§ 1.6. The commissioner may certify a facility or individual for the provision of therapeutic consultation or residential support services for which reimbursement is sought from the Department of Medical Assistance Services only after he is satisfied that individuals providing therapeutic consultation under the waiver meet the

standards in § 1.5 of Article 4 of these regulations; or (ii) all individuals providing residential support services to waiver recipients have passed an objective test of knowledge, skills and abilities approved by the Department. In addition, the Commissioner must be satisfied that the facility or individual can:

1. Demonstrate the ability to serve individuals in need of services regardless of the individual's ability to pay or eligibility for medicaid reimbursement;

2. Meet the administrative and financial management requirements of state and federal regulations; and

3. Document and maintain individual case records in accordance with state and federal requirements.

§ 1.7. The Commissioner may issue a certification to a facility or individual that has fulfilled the conditions listed in § 1.6 for any period not to exceed two (2) years from its date of issuance, unless it is revoked or surrendered earlier.

§ 1.8. The Commissioner may revoke or suspend any certification issued, or refuse issuance of a certification on any of the following grounds:

1. Permitting, aiding or abetting the commission of an illegal act.

2. Conduct or practices detrimental to the welfare of any client.

3. Failure of individuals to meet the standards set forth under these regulations.

§ 1.9. Whenever the Commissioner revokes, suspends or denies a certification, the provisions of the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) shall apply.

§ 1.10. If a certification is revoked or refused as herein provided, a new application for certification may be considered by the Commissioner when the conditions upon which such action was based have been corrected and satisfactory evidence of this fact has been furnished.

§ 1.11. Suspension of a certification shall in all cases be for an indefinite time and the suspension may be lifted and rights under the certification fully or partially restored at such time as the Commissioner determines that the rights of the certified facility or individual appear to so require and the interests of the public will not be jeopardized.

Article 6.
Inspection.

§ 1.12. Each applicant or certified facility or individual agrees as a condition of application or certification to permit properly designated representatives of the Department to examine records to verify information contained in the application.

PART II.
REQUIREMENTS.

Article 1.
Staff Qualifications.

§ 2.1. The facility or individual shall meet the following standards to provide therapeutic consultation services reimbursable under the waiver by the Department of Medical Assistance Services:

1. Psychologists shall be licensed by the Department of Health Professions.

2. Occupational Therapists shall be certified by the Department of Health Professions.

3. Physical Therapists shall be licensed by the Department of Health Professions.

4. Speech Therapists shall be licensed by the Department of Health Professions.

5. Social Workers shall be licensed by the Department of Health Professions.

6. Behavioral therapy consultation must be provided by individuals who are endorsed by the Department as meeting knowledge, skills and abilities as determined by the Department and attached hereto.

§ 2.2. The facility or individual shall request reimbursement from the Department of Medical Assistance Services for residential support services provided to waiver recipients only when the services were provided by individuals who have passed an objective test of knowledge, skills and abilities approved by the Department.

Article 2.
Facility or Individual Requirements.

§ 2.3. The facility or individual must:

1. Demonstrate the ability to serve individuals in need of services regardless of the individuals's ability to pay or eligibility for medicaid reimbursement;

2. Have the administrative and financial management capacity to meet state and federal requirements; and

3. Have the ability to document and maintain individual case records in accordance with state and federal requirements.

POSITION QUALIFICATIONS

The incumbent must have the following knowledge, skills

and abilities for Behavior Therapy Consultation. These must be documented or observable in the application form or supporting documentation.

KNOWLEDGE OF:

- *the definition and causes of mental retardation and program philosophy of mental retardation services*
- *behavior assessment and functional analysis*
- *behavior modification techniques utilized with MR and DD populations*
- *methods of data collection, analysis and interpretation*
- *methods of training and consultation*
- *consumer rights and ethical principles of behavior intervention*

DEMONSTRATED ABILITIES TO:

- *conduct behavior assessment*
- *write a functional analysis of behavior*
- *develop and present effective and practical behavior plan*
- *train direct service providers*
- *develop data collection procedures*
- *analyze and interpret behavioral data and make program decisions/adjustments*
- *ability to communicate effectively both written and orally*

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

Title of Regulation: **VR 615-01-36. General Relief (GR) Program - Locality Options.**

Statutory Authority: § 63.1-25 of the Code of Virginia.

Effective Dates: March 1, 1991, through February 29, 1992.

Preamble:

The General Relief (GR) Program is an optional State and locally funded program. If a local department of social services decides to provide assistance from the General Relief Program, the agency receives 62.5% of its reimbursable expenditures from the State. The remaining 37.5% of the reimbursable expenditures and any expenditures that are not reimbursable are paid from local-only funds.

Every agency must have an approved General Relief Plan on file with the Virginia Department of Social Services (VDSS) and must submit any Plan revisions to VDSS for approval. The Plan specifies whether a local department of social services is operating a General Relief Program and if an agency has elected to provide GR, specifies the components and subcomponents (types of assistance) provided and the related options. Options are choices made by local departments that define the assistance provided. They include the types of assistance units served, the amount of assistance provided, the time period for which assistance is available, and the types of unemployability covered.

Local departments of social services have requested that the options available to agencies who participate in the General Relief Program be increased. The agencies stated that the addition of the requested options would allow them to more effectively use dwindling resources to meet increasing needs. With the increased options, agencies could limit assistance to some assistance units and use the money saved to meet other needs.

It is anticipated that some agencies, who might have depleted allocations and thus would have discontinued GR, will have sufficient funds to operate a limited General Relief Program for the rest of the year. The additional options will not increase expenditures for benefit costs since each local department of social services must operate its General Relief Program within its allocation. Since agencies are not required to select these options, whether benefits available in the localities will be reduced is unknown.

Approval of this emergency regulation by the Governor will allow agencies to revise General Relief Programs to include the new options. Each local department of social services will decide which options to include and will submit a General Relief Plan showing the choices made to the Virginia Department of Social Services for approval. After the revised Plan has been approved and an effective date has been established, the agency will implement any changes.

Summary:

This regulation adds options to ten of the General Relief Program components. The options which vary by component include a new assistance unit, limits on assistance received from some components, a second time limit for some components, and a contracted provider requirement for prescription drugs.

SUMMARY

1. REQUEST: The Governor's approval to adopt the emergency regulation entitled "General Relief (GR) Program - Locality Options" effective February 1, 1991 is

requested.

2. PURPOSE OF REQUEST: The revisions included in the regulations expand options available to local agencies. This expansion gives a local department of social services more choices and allows the agency to tailor dwindling resources to meet local needs.

3. PERSONS AFFECTED BY THIS REGULATION: This regulation may affect those persons in the Commonwealth who are applying for or receiving assistance from the General Relief Program on or after February 1, 1991. If a local department of social services does not take action to revise the General Relief Program presently being provided, there will be no impact from this regulation. The regulation does not affect private individuals or small businesses.

4. BACKGROUND: The General Relief Program is an optional program funded by State and local funds. Each agency decides whether to operate the program and selects the components and subcomponents (types of assistance) to be provided. Depending on the component or subcomponent selected, the agency may make choices from options that define the assistance provided. The options, which vary according to the component or subcomponent, include the types of assistance units that will be served, the amount of assistance that will be provided, and the time period during which assistance is available. The components, subcomponents, and options selected must be specified in the agency's General Relief Plan. The approved Plan is the official record of the General Relief Program operated by an agency.

During the months of October and November 1990, the Department received requests from several local departments of social services for revisions to the General Relief Program. The requested revisions included the addition of several options to components of the General Relief Program that would limit assistance in ways that had not previously been allowed. The agencies stated the addition of these options would allow them to more effectively use available funds.

The revisions adopted by the Board and included in the regulation increase options for ten of the GR components. Therefore, local departments of social services will have more choices regarding assistance to be provided from the General Relief Program. Although agencies are not required to implement the new options, they will be required to submit a revised General Relief Plan to show the choices they have made.

5. AUTHORITY TO ACT: Section 63.1-25 of the Code of Virginia grants the State Board of Social Services the authority to promulgate rules and regulations necessary for operation of public assistance programs in Virginia. On December 19, 1990, the Board voted to approve the revisions to the General Relief Program and instructed the Department to seek emergency authority to implement the regulation effective February 1, 1991.

6. FISCAL IMPACT: Since each agency must operate the General Relief Program within its allocation, expenditures for benefits will not be increased by the addition of the options. Expenditures for benefits may be decreased if agencies select the new options to reduce General Relief expenditures, and use local funds that would have been used to match State funds for other purposes. Administrative costs to implement the regulation will be absorbed by the Department of Social Services's budget.

7. FUTURE DEPARTMENT ACTION: The Department plans to comply with the Administrative Process Act requirements governing promulgation of regulations.

/s/ Larry D. Jackson
Commissioner
Date: January 14, 1991

VR 615-01-36. General Relief (GR) Program - Locality Options

1. Definitions.

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

"Aid to Dependent Children (ADC)" means the program supervised by the Virginia Department of Social Services and administered by local departments of social services that provides support to a relative for eligible children.

"Agency" means the local department of social services.

"Assistance for unattached children" means a component of the General Relief Program that can provide assistance to children who would be eligible for ADC if the relationship requirement was met.

"Assistance for unemployed employable individuals" means a component of the General Relief Program that can provide assistance to individuals who are unemployed but employable.

"Assistance for unemployable individuals" means a component of the General Relief Program that can provide assistance to individuals who meet unemployability requirements.

"Assistance unit" means the individual or group of individuals whose needs, income, and resources are considered in determining eligibility for a component.

"Clothing assistance" means a component of the General Relief Program that can be used to purchase clothing for individuals who have an emergency need.

"Component" means a specific type of assistance provided under the General Relief Program.

"Emergency medical assistance" means a component c

the General Relief Program that can be used to purchase medical assistance for individuals who have an emergency need. The component is composed of 11 subcomponents including prescription drugs.

"Food credit authorization assistance" means a component of the General Relief Program that can be used to purchase food for individuals who have an emergency need.

"General Relief Plan" means the document completed by a local department of social services to identify the components included in the General Relief Program for the locality.

"General Relief Program (GR)" means an optional program funded by State (62.5%) and local funds (37.5%) with the primary purpose of assisting individuals who do not qualify for aid in a federal category (ADC or SSI). The program is supervised by the State Department of Social Services and administered by local agencies. Each agency chooses the components and subcomponents to be included in its General Relief Program.

"Interim assistance" means a component of the General Relief Program that can provide assistance to individuals who have applied for SSI, who must apply for SSI, or are appealing a SSI decision.

"Locality" means the area served by a local department of social services.

"Maximum for the locality" means the amount of reimbursable assistance that can be provided by an agency for some components based on the locality's group.

"Monthly maximum" means the dollar amount of assistance specified for some GR components in the General Relief Plan.

"Ongoing medical assistance" means a component of the General Relief Program that can be used to provide individuals continuing medical assistance. The component is composed of 10 subcomponents including prescription drugs.

"Plan" means the General Relief Plan.

"Reimbursable" means the amount an assistance unit can receive per month for which the State/local match is available.

"Relocation assistance" means a component of the General Relief Program that can be used to move individuals who have an emergency need.

"Shelter assistance" means a component of the General Relief Program that can be used to provide shelter needs of individuals who have an emergency need. The component's two subcomponents are rent/house payments and utility payments.

"Standard of assistance at 90% of need" means the amount of reimbursable assistance that can be provided by an agency for some components based on the size of the assistance unit and the locality's group.

"Subcomponent" means a part of a component.

"Supplemental Security Income (SSI)" means a federal program that assists eligible aged, blind, and disabled individuals.

2. Assistance for unemployed employable individuals.

An agency electing to provide this component will specify in its General Relief Plan the types of assistance units served. The choices are:

A. Parents and their minor children.

B. A parent and minor children.

C. A married couple with no children.

D. One individual.

E. An unmarried pregnant woman.

3. Assistance for unemployable individuals.

An agency electing to provide this component will specify in its General Relief Plan the amount of assistance that can be received by an assistance unit in 12 consecutive months. The choices are:

A. The standard of assistance at 90% of need times three.

B. The standard of assistance at 90% of need times six.

C. The standard of assistance at 90% of need times nine.

D. The standard of assistance at 90% of need times 12 or the maximum for the locality times 12.

4. Ongoing medical assistance.

A. Amount of assistance.

An agency electing to provide this component will specify in its General Relief Plan the amount of assistance that can be received by an assistance unit in 12 consecutive months. The choices are:

1. Three times the monthly maximum.

2. Six times the monthly maximum.

3. Nine times the monthly maximum.

4. Twelve times the monthly maximum.

B. Prescription drugs.

An agency electing to provide this subcomponent will specify in its General Relief Plan whether recipients are required to obtain drugs at a pharmacy with an agency contract. The choices are:

1. Recipients are not required to buy prescription drugs from a contracted pharmacy.

2. Recipients are required to buy prescription drugs from a contracted pharmacy.

5. Interim assistance.

An agency that elects to provide this component but does not elect to provide assistance for unemployable individuals will specify in its General Relief Plan whether interim assistance will be restricted to assistance units with an individual with a disability that will last 12 months, has lasted 12 months, or will result in death.

The choices are:

A. Assistance will be not be restricted.

B. Assistance will be restricted.

6. Assistance for unattached children.

An agency electing to provide this component will specify in its General Relief Plan the amount of assistance that can be received by an assistance unit in 12 consecutive months. The choices are:

A. The standard of assistance at 90% of need times three.

B. The standard of assistance at 90% of need times six.

C. The standard of assistance at 90% of need times nine.

D. The standard of assistance at 90% of need times 12 or the maximum for the locality times 12.

7. Food credit authorization assistance.

An agency electing to provide this component will specify in its General Relief Plan the maximum number of months that assistance can be received by an assistance unit. The choices are:

A. Assistance will be provided for a maximum of one to six months out of six consecutive months.

B. Assistance will be provided for a maximum of one to twelve months out of 12 consecutive months.

8. Shelter assistance.

A. Maximum number of months.

An agency electing to provide this component will specify in its General Relief Plan the maximum number of months that assistance can be received by an assistance unit. The choices are:

1. Assistance will be provided for a maximum of one to six months out of six consecutive months.

2. Assistance will be provided for a maximum of one to twelve months out of 12 consecutive months.

B. Rent/house payments.

An agency electing to provide this subcomponent will specify in its General Relief Plan the maximum number of months that assistance can be received by an assistance unit. The choices are:

1. Assistance will be provided for a maximum of one to six months out of six consecutive months.

2. Assistance will be provided for a maximum of one to twelve months out of 12 consecutive months.

C. Utility payments.

An agency electing to provide this subcomponent will specify in its General Relief Plan the maximum number of months that assistance can be received by an assistance unit. The choices are:

1. Assistance will be provided for a maximum of one to six months out of six consecutive months.

2. Assistance will be provided for a maximum of one to twelve months out of 12 consecutive months.

9. Emergency medical assistance.

A. Maximum number of months.

An agency electing to provide this component will specify in its General Relief Plan the maximum number of months that assistance can be received by an assistance unit. The choices are:

1. Assistance will be provided for a maximum of one to six months out of six consecutive months.

2. Assistance will be provided for a maximum of one to twelve months out of 12 consecutive months.

B. Prescription drugs.

An agency electing to provide this subcomponent will specify in its General Relief Plan whether recipients are required to obtain drugs at a pharmacy with an agency

contract. The choices are:

1. Recipients are not required to buy prescription drugs from a contracted pharmacy.

2. Recipients are required to buy prescription drugs from a contracted pharmacy.

10. Clothing assistance.

An agency electing to provide this component will specify in its General Relief Plan the maximum number of months that assistance can be received by an assistance unit. The choices are:

A. Assistance will be provided for a maximum of one to six months out of six consecutive months.

B. Assistance will be provided for a maximum of one to twelve months out of 12 consecutive months.

11. Relocation assistance.

An agency electing to provide this component will specify in its General Relief Plan the maximum number of months that assistance can be received by an assistance unit. The choices are:

A. Assistance will be provided for a maximum of one to six months out of six consecutive months.

B. Assistance will be provided for a maximum of one to twelve months out of 12 consecutive months.

/s/ Larry D. Jackson
Commissioner
Date: January 14, 1991

/s/ Lawrence Douglas Wilder
Governor
Date: February 20, 1991

Joan W. Smith
Registrar of Regulations
Date: February 22, 1991

DIRECTOR'S ORDER NUMBER FIVE (91)

"FAST TRAC"; PROMOTIONAL GAME AND DRAWING RULES

In accordance with the authority granted by § 58.1-4006A of the Code of Virginia, I hereby promulgate the "Fast Trac" promotional game and drawing rules for the kickoff events which will be conducted at various lottery retailer locations throughout the Commonwealth on Thursday, March 14, 1991. These rules amplify and conform to the duly adopted State Lottery Board regulations for the conduct of lotteries.

The rules are available for inspection and copying during normal business hours at the State Lottery Department headquarters, 2201 West Broad Street, Richmond, Virginia, and at each of the State Lottery Department regional offices. A copy may be requested by mail by writing to: Marketing Division, State Lottery Department, P. O. Box 4689, Richmond, Virginia 23220.

This Director's Order becomes effective on the date of its signing and shall remain in full force and effect until March 30, 1991, unless otherwise extended by the Director.

/s/ Kenneth W. Thorson, Director
Date: March 1, 1991

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DIRECTOR'S ORDER NUMBER SEVEN (91)

"FAST TRACK TO CASH"; VIRGINIA LOTTERY RETAILER SALES PROMOTIONAL PROGRAM AND RULES

In accordance with the authority granted by § 58.1-4006A of the Code of Virginia, I hereby promulgate the "Fast Track to Cash" Virginia Lottery Retailer Sales Promotional Program and Rules for the lottery retailer incentive program which will be conducted from Monday, March 4, 1991 through Monday, April 29, 1991. These rules amplify and conform to the duly adopted State Lottery Board regulations.

These rules are available for inspection and copying during normal business hours at the State Lottery Department headquarters, 2201 West Broad Street, Richmond, Virginia, and at each of the State Lottery Department regional offices. A copy may be requested by mail by writing to: Marketing Division, State Lottery Department, P. O. Box 4689, Richmond, Virginia 23220.

This Director's Order becomes effective on the date of its signing and shall remain in full force and effect unless amended or rescinded by further Director's Order.

/s/ Kenneth W. Thorson, Director
Date: March 1, 1991

FINAL REGULATIONS

Title of Regulation: **VR 447-01-2. Administration Regulations.**

Statutory Authority: § 58.1-4007 of the Code of Virginia.

Effective Date: April 24, 1991.

Summary:

The State Lottery Department is amending numerous sections of the Administration Regulations which set out the general operational parameters for the department and the board. They include industry-related definitions; requirements for approval of banks and depositories; board procedures for the conduct of business and promulgation of regulations; procedures for appeals on licensing actions; standards for agency procurement action; and procedures for procurement appeals and disputes.

The amendments to the procurement procedures establish new guidelines for competitive procurement of professional services; expand sole source procurement; exempt from competitive procurement procedures purchases under $1,000, nonprofessional services under $5,000 and emergency purchases; and limit change orders to a total of $10,000 for one contract. Although similar to the regulations under which other state agencies operate, these regulations would allow more flexibility in purchasing goods and services.

Other revisions address Code requirements, definition changes and housekeeping measures.

Subsequent to publication of the regulations in proposed form, revisions were made to §§ 4.4, 4.5, 4.6 and 4.7 to add a requirement that the department post certain written procurement notices for not less than five working days. Current regulations do not provide any minimum time requirement for the posting of notices. The department uses other more effective methods of giving notice to prospective vendors and other members of the public; therefore, five working days would be adequate for the proforma requirement.

VR 447-01-2. Administration Regulations.

PART I.
GENERAL PARAMETERS.

§ 1.1. Definitions.

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

"Altered ticket" means a lottery ticket which has been

forged, counterfeited or altered.

"Award" means a decision to contract with a specific vendor for a specific contract.

"Bank" means and includes any commercial bank, savings bank, savings and loan association, credit union, trust company, and any other type or form of banking institution organized under the authority of the Commonwealth of Virginia or of the United States of America whose principal place of business is within the Commonwealth of Virginia and which is designated by the State Treasurer to perform functions, activities or services in connection with the operations of the lottery for the deposit and handling of lottery funds, the accounting of those funds and the safekeeping of records.

"Bearer instrument" means a lottery ticket which has not been signed by or on behalf of a person or a legal entity. Any prize won on an unsigned ticket is payable to the holder, or bearer, of that ticket.

"Bid" means a competitively priced offer made by an intended seller, usually in reply to an invitation for bids.

"Bid bond" means an insurance agreement in which a third party agrees to be liable to pay a certain amount of money in the event a specific bidder fails to accept the contract as bid.

"Board" means the State Lottery Board established by the state lottery law.

"Book," "ticket book," or *"pack"* generally means a set quantity of individually wrapped unbroken, consecutively numbered, fanfolded instant game tickets which all bear an identical book or pack number which is unique to that book or pack among all the tickets printed for a particular game.

"Competitive bidding" means the offer of firm bids by individuals or firms competing for a contract, privilege, or right to supply specified services or goods.

"Competitive negotiation" means a method for purchasing goods and services, usually of a highly complex and technical nature where qualified individuals or firms are solicited by using a Request For Proposal. Discussions are held with selected vendors and the best offer, as judged against criteria contained in the Request For Proposal, is accepted.

"Consideration" means something of value given for a promise to make the promise binding. It is one of the essentials of a legal contract.

"Contract" means an agreement, enforceable by law, between two or more competent parties. It includes any type of agreement or order for the procurement of goods or services.

"Contract administration" means the management of all facets of a contract to assure that the contractor's total performance is in accordance with the contractual commitments and that the obligations of the purchase are fulfilled.

"Contracting officer' means the person(s) authorized to sign contractual documents which obligate the State Lottery Department and to make a commitment against State Lottery Department funds.

"Contractor" means an individual or firm which has entered into an agreement to provide goods or services to the State Lottery Department.

"Department" means the State Lottery Department created by the state lottery law.

"Depository" means any person, including a bonded courier service, armored car service, bank, central or regional offices of the department, or state agency, which performs any or all of the following activities or services for the lottery:

1. The safekeeping and distribution of tickets to retailers,

2. The handling of lottery funds,

3. The deposit of lottery funds, or

4. The accounting for lottery funds.

"Director" means the Director of the State Lottery Department or his designee.

"Electronic funds transfer (EFT)" means a computerized transaction that withdraws or deposits money against a bank account ~~on a set day based on the balance owed by the bank account holder to the lottery department or due to the bank account holder from the lottery department~~ .

"Erroneous ticket" means ~~an instant lottery ticket which has been forged, counterfeited or altered~~ *a lottery ticket which contains an unintentional manufacturing or printing defect. A player holding such a lottery ticket is entitled to a replacement ticket of equal value .*

"Game" means any individual or particular type of lottery authorized by the board.

"Goods" means any material, equipment, supplies, printing, and automated data processing hardware and software.

"Household" means members of a group who live together as a family unit. It includes, but is not limited to, members who may be claimed as dependents for income tax purposes.

"Informalities" means defects or variations of a bid

from the exact requirements of the Invitation for Bid which do not affect the price, quality, quantity, or delivery schedule for the goods or services being purchased.

"Inspection" means the close and critical examination of goods and services delivered to determine compliance with applicable contract requirements or specifications. It is the basis for acceptance or rejection.

"Instant game" means a game that uses preprinted tickets with a latex covering over a portion of the ticket. The covering is scratched off by the player to reveal immediately whether the player has won a prize or entry into a prize drawing. *An instant game may include other types of non-on-line lottery games.*

"Instant ticket" means ~~a ticket for~~ an instant game *ticket with a latex covering the game symbols located in the play area. Each ticket has a unique validation number and ticket number .*

"Invitation for Bids (IFB)" means a document used to solicit bids for buying goods or services. It contains or references the specifications or scope of work and all contractual terms and conditions.

"Kickbacks" means gifts, favors or payments to improperly influence procurement decisions.

"Legal entity" means an entity, other than a natural person, which has sufficient existence in legal contemplation that it can function legally, sue or be sued and make decisions through agents, as in the case of a corporation.

"Letter contract" means a written preliminary contractual instrument that authorizes a contractor to begin immediately to produce goods or perform services.

"License approval notice" means the form sent to the retailer by the lottery department notifying him that his application for a license has been approved and giving him instructions for obtaining the required surety bond and setting up his lottery bank account.

"Lottery" or *"state lottery"* means the lottery or lotteries established and operated in response to the provisions of the state lottery law.

"Lottery license" or "retailer license" means the official document issued by the department to a person authorizing him to sell or dispense lottery tickets, materials or lottery games at a specified location in accordance with all regulations, terms and conditions, and instructions and directives issued by the board and the director.

"Lottery retailer" or *"lottery sales retailer"* or *"retailer"* means a person licensed by the director to sell and dispense lottery tickets, materials or lottery games for instant *lottery games* or *for both instant and* on-line lottery games ~~; or both~~ .

~~"Lottery license" or "retailer license" means the official document issued by the department to a person authorizing him to sell or dispense lottery tickets, materials or lottery games at a specified location in accordance with all regulations, terms and conditions, and instructions and directives issued by the board and the director.~~

"Low-tier winner" or *"low-tier winning ticket"* means an instant game ticket which carries a cash prize of $25 or less or a prize of additional unplayed instant tickets.

"Negotiation" means a bargaining process between two or more parties, each with its own viewpoints and objectives, seeking to reach a mutually satisfactory agreement on, or settlement of, a matter of common concern.

"Noncompetitive negotiations" means the process of arriving at an agreement through discussion and compromise when only one procurement source is practicably available or competitive procurement procedures are otherwise not applicable

"Nonprofessional services" means personal services not defined as "professional services."

"Notice of Award" means a written notification to a vendor stating that the vendor has received a contract with the department.

"Notice of Intent to Award" means a written notice which is publicly displayed, prior to signing of a contract, that shows the selection of a vendor for a contract.

"Pack" means the same thing as "book."

"Performance bond" means a contract of guarantee executed in the full sum of the contract amount subsequent to award by a successful bidder to protect the department from loss due to his inability to complete the contract in accordance with its terms and conditions.

"Person" means a natural person and may extend and be applied to bodies politic and corporate unless the context indicates otherwise.

"Personal services contract" means a contract in which the department has the right to direct and supervise the employee(s) of outside business concerns as if the person(s) performing the work were employees of the department or a contract for personal services from an independent contractor.

"Prize" means any cash or noncash award to holders of winning tickets.

"Procurement" means the procedures for obtaining goods or services. It includes all activities from the

planning steps and preparation and processing of a request through the processing of a final invoice for payment.

"Professional services" means services within the practice of accounting, architecture, behavioral science, dentistry, insurance consulting, land surveying, landscape architecture, law, medicine, optometry, pharmacy, professional engineering, veterinary medicine and lottery on-line and instant ticket services.

"Protest" means a complaint about an administrative action or decision brought by a vendor to the department with the intention of receiving a remedial result.

"Purchase order" (signed by the procuring activity only) means the form which is used to procure goods or services when a bilateral contract document, signed by both parties, is unnecessary, particularly for small purchases. The form may be used for the following:

1. To award a contract resulting from an Invitation For Bids (IFB).

2. To establish a blanket purchase agreement.

3. As a delivery order to place orders under state contracts or other rquirements-type contracts which were established for such purpose.

"Request for Information (RFI)" means a document used to get information from the general public or potential vendors on a good or service. The department may act upon the information received to enter into a contract without issuing an IFB or an RFP.

"Request for Proposals (RFP)" means a document used to solicit offers from vendors for buying goods or services. It permits negotiation with vendors (to include prices) as compared to competitive bidding used in the invitation for bids.

"Responsible vendor" means a person or firm who has the capability in all respects to fully satisfy the requirements of a contract as well as the business integrity and reliability to assure good faith performance. In determining a responsible vendor, a number of factors including but not limited to the following are considered. The vendor should:

1. Be a regular dealer or supplier of the goods or services offered;

2. Have the ability to comply with the required delivery or performance schedule, taking into consideration other business commitments;

3. Have a satisfactory record of performance; and

4. Have the necessary facilities, organization, experience, technical skills, and financial resources to fulfill the terms of the contract.

"Responsive vendor" means a person or firm who has submitted a bid, proposal, offer or information which conforms in all material respects to the solicitation.

"Sales," "gross sales," "annual sales" and similar terms mean total ticket sales including any discount allowed to a retailer for his ~~commission~~ *compensation* and, ~~in the case of instant game sales,~~ any discount or adjustment allowed for the retailer's payment of prizes of less than $600.

"Services" means any work performed by a vendor where the work is primarily labor or duties and is other than providing equipment, materials, supplies or printing.

"Sole source" means *that only one source is practicably available to furnish* a product or service ~~which is practicable~~ .

"Solicitation" means an Invitation for Bids (IFB), a Request for Proposals (RFP), a Request for Information (RFI) or any other document issued by the department or telephone calls by the department to obtain bids or proposals or information for the purpose of entering into a contract.

"Surety bond" means an insurance agreement in which a third party agrees to be liable to pay a specified amount of money to the department in the event the retailer fails to meet his obligations to the department.

"Ticket number" means the preprinted unique number or combination of letters and numbers which identifies that particular ticket as one ~~of a series of tickets~~ *within a particular game or drawing* .

"Validation code" means the ~~multi-letter~~ *multiletter* or ~~multi-number~~ *multinumber* code which appears among the play symbols under the latex covering on *the play area of* an instant ticket. The validation code *, also known as retailer validation code,* is used to verify prize winning tickets.

"Validation number" means the unique number or number-and-letter code printed on the front of an instant ticket sometimes under a latex covering bearing the words "Do not remove," "Void if removed" or similarly worded label *, or the unique number assigned by the on-line central computer and printed on the front of each on-line ticket* .

"Vendor" means one who can sell, supply or install goods or services for the department.

§ 1.2. Generally.

The purpose of the state lottery is to produce revenue consistent with the integrity of the Commonwealth and the general welfare of its people. The operations of the State Lottery Board and the State Lottery Department will be conducted efficiently, honestly and economically.

§ 1.3. State Lottery Board.

A. Monthly meetings.

The board will hold monthly public meetings to receive information and recommendations from the director on the operation and administration of the lottery and to take official action. It may also request information from the public. The board may have additional meetings as needed. (See Part III, Board Procedures.)

B. Inspection of department records.

At the board's request, the department shall produce for review and inspection the department's books, records, files and other information and documents.

§ 1.4. Director.

The director shall administer the operations of the State Lottery Department following the authority of the Code of Virginia and these regulations.

§ 1.5. Ineligible players of the lottery.

Board members, officers or employees of the lottery, or any board member, officer or employee of any vendor to the lottery of lottery on-line or instant ticket goods or services working directly with the department on a contract for such goods or services, or any person residing in the same household as any such board member, officer or employee may not purchase tickets or receive prizes of the lottery.

§ 1.6. Advertising.

A. Generally.

Advertising may include but is not limited to print advertisements, radio and television advertisements, billboards, point of purchase and point of sale display materials. The department will not use funds for advertising which is for the primary purpose of inducing people to play the lottery.

B. Lottery retailer advertising.

Any lottery retailer may use his own advertising materials if the department has approved its use in writing before it is shown to the public. The department shall develop written guidelines for giving such approval.

C. *Information provided by department.*

The department may provide information displays or other material to the retailer. The retailer shall position the material so it can be seen easily by the general public.

D. *Special advertising.*

The department may produce special posters, brochures or flyers describing various aspects of the lottery and provide these to lottery retailers to post or distribute.

E. *Winner advertising.*

The department may use interviews, pictures or statements from people who have won lottery prizes to show that prizes are won and awarded; however, in no case shall the use of interviews, pictures or statements be for the primary purpose of inducing persons to participate in the lottery.

F. *Other advertising.*

The department may use other informational and advertising items which may include any materials deemed appropriate advertising, informational, and educational media which are not for the primary purpose of inducing people to play the lottery.

§ 1.7. Operations of the department.

A. Generally.

The department shall be operated in a manner which considers the needs of the Commonwealth, *lottery retailers,* the public ~~at-large~~ , the convenience of the ticket purchasers, and winners of lottery prizes.

B. Employment.

The department shall hire people without regard to race, sex, color, national origin, religion, age, handicap, or political affiliation.

1. All employees shall be recruited and selected in a manner consistent with the policies which apply to classified positions.

2. Sales and marketing employees are exempt from the Virginia Personnel Act.

C. Internal operations.

The department will operate under the internal administrative, accounting and financial controls specifically developed for the State Lottery Department under the applicable policies required by the Departments of Accounts, Planning and Budget, Treasury, State Internal Auditor and by the Auditor of Public Accounts.

1. Internal operations include, but are not limited to, ticket controls, money receipts and payouts, payroll and leave, budgeting, accounting, revenue forecasting, purchasing and leasing, petty cash, bank account reconciliation and fiscal report preparation.

2. Internal operations apply to automated and manual systems.

D. External operations.

The department will conduct business with the public, lottery retailers, vendors and others with integrity and honesty.

E. Apportionment of lottery revenue.

Moneys received from lottery sales will be divided approximately as follows:

50%	Prizes
45%	State Lottery Fund Account (On and after July 1, 1989, administrative costs of the lottery shall not exceed 10% of *total annual estimated* gross *revenues to be generated from lottery* sales.)
5.0%	Lottery retailer discounts

F. State Lottery Fund Account.

The State Lottery Fund will be established as an account in the Commonwealth's accounting system. The account will be established following usual procedures and will be under regulations and controls as other state accounts. ~~Prior to the start of the first lottery game, the account will be funded from the proceeds of a Department of Treasury loan or loans (treasury loan). Thereafter, funding~~ *Funding* will be from gross sales.

1. Within the State Lottery Fund, there shall be established a "Special Reserve Fund" which shall contain the following subaccounts:

a. An "Operations Special Reserve Fund" subaccount for administrative and operations costs will be created in the State Lottery Fund account. On June 30, 1989, $1 million dollars shall be transferred into the Operations Special Reserve Fund. Thereafter, 1.7% of gross monthly revenues from sales shall be transferred to the Operations Special Reserve Fund until the Operations Special Reserve equals not less than 1.7% of estimated annual gross lottery revenues from sales. ~~Commencing with lottery operations, but prior to initial sales, all funds derived from the start-up treasury loan(s) shall be deposited to the Operations Special Reserve Fund. Except as otherwise provided in these regulations, start-up treasury loan fund balances shall remain in the Operations Special Reserve Fund until exhausted, until transferred to the Lottery Start-up Payback Special Reserve Fund or until 12 months after initial lottery sales at which time any fund balance from the start-up treasury loan(s) shall revert to the General Fund.~~

b. A "Lottery Prize Special Reserve Fund" subaccount will be created in the State Lottery Fund account and will be used when lottery prize pay-outs exceed department cash on hand. Immediately prior to initial lottery sales, $500,000 shall be transferred to the Lottery Prize Special Reserve Fund from start-up treasury loan funds in the State Lottery Fund. Thereafter, 5.0% of monthly gross sales shall be transferred to the Lottery Prize Special Reserve Fund until the amount of the Lottery Prize Special Reserve Fund reaches 5.0% of the gross lottery revenue from the previous year's annual sales or $5 million dollars, whichever is less.

(1) The calculation of the 5.0% will be made for each instant or on-line game.

(2) The funding of this subaccount may be adjusted at any time by the board.

2. ~~Until July 1, 1989, or when start-up funds are totally repaid, a special subaccount titled "Lottery Start-up Payback Special Reserve Fund" will be established to retire the start-up treasury loan(s).~~

~~a. Five percent of the state lottery fund balance, excluding funds derived from start-up treasury loan(s), at the beginning of each month will be placed in this subaccount. The director may increase this percentage when, in his judgment, sufficient funds remain in the State Lottery Fund to meet other needs and shall increase the percentage when necessary to retire the treasury loan(s) within the first 12 months from initial lottery sales.~~

~~b. The director may, at any time, direct the transfer from the State Lottery Fund balance to the "Lottery Start-up Payback Special Reserve Fund" of all or any portion of any funds derived from the start-up treasury loan(s) which, in his judgment are no longer required to fund lottery operations.~~

~~c. The director may, from time to time, direct the transfer of all or a portion of the Lottery Start-up Payback Special Reserve Fund to the General Fund of the Treasury to retire all or a portion of the start-up treasury loan(s). The director shall ensure that the entire amount of the start-up treasury loan(s) is repaid within the first 12 months of lottery sales.~~ *Reserved.*

3. Other subaccounts may be established in the State Lottery Fund account as needed at the direction of the board upon the request of the director ~~or the internal auditor~~ with concurrence of the State Comptroller ; ~~State Treasurer~~ and the Auditor of Public Accounts.

G. Administrative and operations costs.

Lottery expenses include, but are not limited to, ticket costs, vendor fees, consultant fees, advertising costs, salaries, rents, utilities, and telecommunications costs.

H. Audit of lottery revenues.

The cost of any audit shall be paid from the State Lottery Fund.

1. The Auditor of Public Accounts or his designee shall conduct a monthly post-audit of all accounts and transactions of the department. When, in the opinion of the Auditor of Public Accounts, monthly post-audits are no longer necessary to ensure the integrity of the lottery, the Auditor of Public Accounts shall notify the board in writing of his opinion and fix a schedule of less frequent post-audits. The schedule of post-audits may, in turn, be further adjusted by the same procedure to require either more or less frequent audits in the future.

2. Annually, the Auditor of Public Accounts shall conduct a fiscal and compliance audit of the department's accounts and transactions.

I. Other matters.

The board and director may address other matters not mentioned in these regulations which are needed or desired for the efficient and economical operation and administration of the lottery.

PART II.
BANKS AND DEPOSITORIES.

§ 2.1. Approval of banks.

The State Treasurer, with the concurrence of the director, and in accordance with applicable Treasury directives, shall approve a bank or banks to provide services to the department.

A. A bank or banks shall serve as agents for electronic funds transfers between the department and lottery retailers as required by these regulations and by contracts between the department, the State Treasury, retailers, and the banks.

B. In selecting the bank or banks to provide these services, the State Treasurer and the director shall consider quality of services offered, the ability of the banks to guarantee the safekeeping of department accounts and related materials, the cost of services provided and the sophistication of bank systems and products.

C. There shall be no limit on the number of banks approved under this section.

§ 2.2. Approval of depositories.

The director may contract with depositories to distribute lottery tickets and materials from the department's central warehouse to the department's regional offices and from the department to retailers, and to collect funds, lottery tickets and lottery materials from retailers.

§ 2.3. Compensation.

A. The contract between each bank or depository and the department shall fix the compensation for services rendered to the department.

B. Compensation of banks will be in the form of compensating balances, direct fees, or some combination of these methods, at the discretion of the department.

C. Depositories will be compensated based on vouchers for services rendered.

§ 2.4. Depository for transfer of tickets.

A. The department may designate one or more depositories to transfer lottery tickets, lottery materials, and related documents between the department and lottery retailers.

~~B. In instances where a retailer wishes delivery of tickets or other materials sooner than scheduled by a lottery depository, the retailer may use his own depository or transfer agent. However, use of a retailer's depository or transfer agency shall have the department's advance approval.~~ *Reserved.*

C. In determining whether to use depositories for transferring tickets, materials and documents between the department and lottery retailers, the department may consider any relevant factor including, but not limited to, cost, security, timeliness of delivery, marketing concerns, sales objectives and privatization of governmental services.

PART III.
LOTTERY BOARD PROCEDURES.

Article 1.
Board Procedures for the Conduct of Business.

§ 3.1. Officers of the board.

A. Chairman and vice-chairman.

The board shall have a chairman and a vice-chairman who shall be elected by the board members.

B. Term of officers.

The board will elect its officers annually at its January meeting to serve for the calendar year.

§ 3.2. Board meetings.

A. Monthly meetings.

The board will hold monthly public meetings to receive information and recommendations from the director on the operation and administration of the lottery and to take official action. The board may also request information from the public.

B. Special meetings.

The board may hold additional meetings as may be necessary to carry out its work. The chairman may call a special meeting at any time and shall call a special meeting when requested to do so by at least two board members or at the request of the director. Notice of special meetings shall be given to all board members at least two calendar days before the meeting. Written notice is preferred but telephonic notice may be accepted by any board member in lieu of written notice.

C. Quorum.

Three or more board members shall constitute a quorum for the conduct of business at both regular and special meetings of the board. A simple majority vote at a regular meeting is sufficient to take official action but official action at a special meeting requires three affirmative votes. The chairman is eligible to vote at all meetings.

D. Conflict of Interest.

If any board member determines that he has a conflict of interest or potential conflict relating to a matter to be considered, that board member shall not take part in such deliberations.

§ 3.3. Committees of the board.

A. Ad hoc committees.

The board chairman may at his discretion appoint such ad hoc committees as he deems necessary to assist the board in its work.

B. Purpose of committees.

An ad hoc committee may be established to advise the board on a matter referred to it or to act on a matter on behalf of the board if so designated.

1. A committee established to act on a matter on behalf of the board shall be composed entirely of board members and shall have at least three members.

a. Three members shall constitute a quorum.

b. Official action of such a committee shall require not fewer than three affirmative votes with each member including the chairman having one vote.

c. If a committee's vote results in an affirmative vote of only two members, the committee shall present a recommendation to the board and the board shall then take action on the matter.

2. A committee established to act in an advisory capacity to the board may include members of the general public. At least two members shall be board members and the chairman shall be a board member appointed by the board chairman.

a. A majority of the members appointed to an advisory committee constitutes a quorum.

b. Recommendations of an advisory committee may be adopted by a majority vote of those present and voting. The chairman of an advisory committee shall be eligible to vote on all recommendations.

c. All actions of advisory committees shall be presented to the board in the form of recommendations.

Article 2.
Procedures for Appeals on Licensing Actions.

§ 3.4. Hearings on denial, suspension or revocation of a retailer's license.

A. Generally.

An *instant lottery retailer* applicant *or an instant lottery retailer surveyed for an on-line license* who is denied a license or a retailer whose license is denied for renewal or is suspended or revoked may appeal the licensing decision and request a hearing on the licensing action.

B. Hearings to conform to Administrative Process Act provisions.

The conduct of license appeal hearings will conform to the provisions of Article 3 (§ 9-6.14:11 et seq.) of Chapter 1.1:1 of Title 9 of the Code of Virginia relating to Case Decisions.

1. An initial hearing consisting of an informal fact finding process will be conducted by the director in private to attempt to resolve the issue to the satisfaction of the parties involved.

2. If an appeal is not resolved through the informal fact finding process, a formal hearing will be conducted by the board in public. The board will then issue its decision on the case.

3. Upon receipt of the board's decision on the case, the appellant may elect to pursue court action in accordance with the provisions of the Administrative Process Act (APA) relating to Court Review.

§ 3.5. Procedure for appealing a licensing decision.

A. Form for appeal.

Upon receiving a notice that (i) an application for or the renewal of a license has been denied by the director, or (ii) the director intends to or has already taken action to suspend or revoke a current license, the applicant or

licensed retailer may appeal in writing for a hearing on the licensing action. The appeal shall be submitted within 30 days of receipt of the notice of the licensing action.

1. Receipt is presumed to have taken place not later than the third day following mailing of the notice to the last known address of the applicant or licensed retailer. If the third day falls upon a day on which mail is not delivered by the United States Postal Service, the notice is presumed to have been received on the next business day. The "last known address" means the address shown on the application of an applicant or licensed retailer.

2. The appeal will be timely if it bears a United States Postal Service postmark showing mailing on or before the 30th day prescribed in § 3.5.A.

B. Where to file appeal.

An appeal to be mailed shall be addressed to:

State Lottery Director
State Lottery Department
Post Office Box 4689
Richmond, Virginia 23220

An appeal to be hand delivered shall be delivered to:

State Lottery Director
State Lottery Department
Bookbindery Building
2201 West Broad Street
Richmond, Virginia 23220

1. An appeal delivered by hand will be timely only if received at the headquarters of the State Lottery Department within the time allowed by § 3.5.A.

2. Delivery to State Lottery Department regional offices or to lottery sales personnel by hand or by mail is not effective.

3. The appellant assumes full responsibility for the method chosen to file the notice of appeal.

C. Content of appeal.

The appeal shall state:

1. The decision of the director which is being appealed;

2. The basis for the appeal;

3. The retailer's license number or the Retailer License Application Control Number; and

4. Any additional information the appellant may wish to include concerning the appeal.

§ 3.6. Procedures for conducting informal fact finding licensing hearings.

A. Director to conduct informal hearing.

The director will conduct an informal fact finding hearing with the appellant for the purpose of resolving the licensing action at issue.

B. Hearing date and notice.

The director will hold the hearing as soon as possible but not later than 30 days after the appeal is filed. A notice setting out the hearing date, time and location will be sent to the appellant at least 10 days before the day set for the hearing.

C. Place of hearings.

All informal hearings shall be held in Richmond, Virginia, unless the director decides otherwise.

D. Conduct of hearings.

The hearings shall be informal. They shall not be open to the public.

1. The hearings will be electronically recorded. The recordings will be kept until any time limits for any subsequent appeals have expired.

2. A court reporter may be used. The court reporter shall be paid by the person who requested him. If the appellant elects to have a court reporter, a transcript shall be provided to the department. The transcript shall become part of the department's records.

3. The appellant may appear in person or may be represented by counsel to present his facts, argument or proof in the matter to be heard and may request other parties to appear to present testimony.

4. The department will present its facts in the case and may request other parties to appear to present testimony.

5. Questions may be asked by any of the parties at any time during the presentation of information subject to the director's prerogative to regulate the order of presentation in a manner which serves the interest of fairly developing the factual background of the appeal.

6. The director may exclude information at any time which he believes is not germane or which repeats information already received.

7. The director shall declare the hearing completed when both parties have finished presenting their information.

E. Director to issue written decision.

Normally, the director shall issue his decision within 15 days after the conclusion of an informal hearing. However, for a hearing with a court reporter, the director shall issue his decision within 15 days after receipt of the transcript of the hearing. The decision will be in the form of a letter to the appellant summarizing the case and setting out his decision on the matter. The decision will be sent to the appellant by certified mail, return receipt requested.

F. Appeal to board for hearing.

After receiving the director's decision on the informal hearing, the appellant may elect to appeal to the board for a formal hearing on the licensing action. The appeal shall be:

1. Submitted in writing within 15 days of receipt of the director's decision on the informal hearing;

2. Mailed to:

Chairman, State Lottery Board
State Lottery Department
Post Office Box 4689
Richmond, Virginia 23220

OR

Hand delivered to:

Chairman, State Lottery Board
State Lottery Department
Bookbindery Building
2201 West Broad Street
Richmond, Virginia 23220

3. The same procedures in § 3.5 B for filing the original notice of appeal govern the filing of the notice of appeal of the director's decision to the board.

4. The appeal shall state:

a. The decision of the director which is being appealed;

b. The basis for the appeal;

c. The retailer's license number or the Retailer License Application Control Number; and

d. Any additional information the appellant may wish to include concerning the appeal.

§ 3.7. Procedures for conducting formal licensing hearings.

A. Board to conduct formal hearing.

The board will conduct a formal hearing within 45 days of receipt of an appeal on a licensing action.

B. Number of board members hearing appeal.

Three or more members of the board are sufficient to hear an appeal. If the chairman of the board is not present, the members present shall choose one from among them to preside over the hearing.

C. Board chairman may designate an ad hoc committee to hear appeals.

The board chairman at his discretion may designate an ad hoc committee of the board to hear licensing appeals and act on its behalf. Such committee shall have at least three members who will hear the appeal on behalf of the board. If the chairman of the board is not present, the members of the ad hoc committee shall choose one from among them to preside over the hearing.

D. Conflict of interest.

If any board member determines that he has a conflict of interest or potential conflict, that board member shall not take part in the hearing. In the event of such a disqualification on a subcommittee, the board chairman shall appoint an ad hoc substitute for the hearing.

E. Notice, time and place of hearing.

A notice setting the hearing date, time and location will be sent to the appellant at least 10 days before the day set for the hearing. All hearings will be held in Richmond, Virginia, unless the board decides otherwise.

F. Conduct of hearings.

The hearings shall be conducted in accordance with the provisions of the Virginia Administrative Process Act (APA). The hearings shall be open to the public.

1. The hearings will be electronically recorded and the recordings will be kept until any time limits for any subsequent court appeals have expired.

2. A court reporter may be used. The court reporter shall be paid by the person who requested him. If the appellant elects to have a court reporter, a transcript shall be provided to the department. The transcript shall become part of the department's records.

3. The provisions of §§ 9-6.14:12 through 9-1.14:14 of the APA shall apply with respect to the rights and responsibilities of the appellant and of the department.

G. Board's decision.

Normally, the board will issue its written decision within 21 days of the conclusion of the hearing. However, for a hearing with a court reporter, the board will issue its

written decision within 21 days of receipt of the transcript of the hearing.

1. A copy of the board's written decision will be sent to the appellant by certified mail, return receipt requested. The original written decision shall be retained in the department and become a part of the case file.

2. The written decision will contain:

a. A statement of the facts to be called "Findings of Facts";

b. A statement of conclusions to be called "Conclusions" and to include as much detail as the board feels is necessary to set out the reasons and basis for its decision; and

c. A statement, to be called "Decision and Order," which sets out the board's decision and order in the case.

H. Court review.

After receiving the board's decision on the case, the appellant may elect to pursue court review as provided for in the Administrative Process Act.

Article 3.
Procedures for Promulgating Regulations.

§ 3.8. Board procedures for promulgating regulations.

[~~A.~~] Generally.

Except for temporary regulations issued under the exemption provided by the Virginia Lottery Law, the board shall promulgate regulations, in consultation with the director, in accordance with the provisions of the Administrative Process Act (Chapter 1.1:1 of Title 9 of the Code of Virginia).

1. The board will provide for a public participation process to be set out in "Guidelines for Public Participation in Regulation Development and Promulgation."

2. Public hearings may be held if the subject matter of a proposed regulation and the level of interest generated through the public participation process warrant them.

~~B. Temporary regulations.~~

~~Temporary regulations to be issued under the exemption provided by law will be adopted by the board at public meetings. The public may provide written comments on newly adopted temporary regulations. The board will consider these comments for later revisions to the regulations.~~

PART IV.
PROCUREMENT.

§ 4.1. Procurement in general.

A. To promote the free enterprise system in Virginia, the State Lottery Department will purchase goods or services by ~~obtaining~~ *using* competitive ~~bids~~ *methods* whenever possible. In its operations and to ensure efficiency, effectiveness and economy, the department will consider using goods and services offered by private enterprise.

B. ~~The director may request other state agencies to review contracts before the department signs them.~~ *Reserved.*

C. The department may purchase goods or services which are under state term contracts established by the Department of General Services, Division of Purchases and Supply, when in the best interest of the State Lottery Department.

D. When time permits, the department may publish notice of procurement actions in "Virginia Business Opportunities ~~:~~ ," *published by the Department of General Services, Division of Purchases and Supplies.*

§ 4.2. Exemption and restrictions.

A. Purchase of goods and services *of $1,000 or less shall be exempted from competitive procurement procedures. Specific purchases of goods and services of more than $1,000* may be exempted from the competitive ~~bidding procedure~~ *procurement procedures* when the director determines in writing that the best interests of the ~~Commonwealth~~ *department* will be served. An exemption may also be declared by the director when an immediate or emergency need exists for goods or services.

B. All purchases shall be made in compliance with the standards of ethics in § ~~5.10~~ *4.23* of these regulations.

C. The department shall not take any procurement action which discriminates on the basis of the race, religion, color, sex, or national origin of any vendor.

D. It is the policy of the Commonwealth of Virginia to contribute to the establishment, preservation, and strengthening of small businesses and businesses owned by women and minorities and to encourage their participation in state procurement activities. Towards that end, the State Lottery Department encourages these firms to compete and encourages nonminority firms to provide for the participation of small businesses and businesses owned by women and minorities through partnerships, joint ventures, subcontracts, and other contractual opportunities.

E. Whenever a purchase is exempt from competitive procurement procedures under these regulations, the contracting officer is obliged to make a determination that

the cost of the goods or services is reasonable under the circumstances. In making this reasonableness determination, the contracting officer may use historical pricing data, and personal knowledge of product and marketplace conditions.

§ 4.3. Requests for information.

A. A Request for Information (RFI) may be used by the department to determine available sources for goods or services.

B. The RFI shall set out a description of the good or service needed, its purpose and the date by which the department needs the information.

C. The RFI may be mailed to interested parties or published by summary notice in general circulation newspapers or other publications.

1. Additional RFI's may be published for a good or a service, as determined on a case-by-case basis.

2. To help ensure competition, the department will ask for information from as many private sector vendors as it determines are necessary.

D. All costs of developing and presenting the information furnished will be paid for by the vendor.

E. The department shall have unlimited use of the information furnished in the reply to an RFI. The department accepts no responsibility for protection of the information furnished unless the vendor requests that proprietary information be protected in the manner prescribed by § 11-52 D of the Code of Virginia. The department shall have no further obligation to any vendor who furnishes information.

F. The department may, at its option, use the responses to the RFI as a basis for entering directly into negotiation with one or more vendors for the purpose of entering into a contract.

§ 4.4. Request for Proposals.

A. A written Request for Proposal (RFP) may be used by the department to describe in general terms the goods or services to be purchased. An RFP may result in a negotiated contract.

B. The RFP will set forth the due date and list the requirements to be used by the vendors in writing the proposal. It may contain other terms and conditions and essential vendor characteristics.

C. The department shall publish or post a public notice of the RFP.

1. All solicitations shall be posted [*for not less than five working days*] on a bulletin board at the State Lottery Department. The notice may also be: mailed to vendors who responded to a Request for Information; published in general circulation newspapers in areas where the contract will be performed; if time permits and at the option of the department, reported to the "Virginia Business Opportunities" at the Department of General Services, Division of Purchases and Supply; and given to any other interested vendor.

2. The department shall decide the method of giving public notice on a case-by-case basis. The decision will consider the means which will best serve *the department's procurement needs and* competition in the private sector.

D. Public openings of the RFP's are not required. If the RFP's are opened in public, only the names of the vendors who submitted proposals will be available to the public.

E. The department will evaluate each vendor proposal.

1. The evaluation will consider the vendor's response to the factors in the RFP.

2. The evaluation will consider whether the vendor is qualified, responsive and responsible for the contract.

F. The department may conduct contract negotiations with one or more qualified vendors. The department may also determine, in its sole discretion, that only one vendor is fully qualified or that one vendor is clearly more highly qualified than the others and negotiate and award a contract to that vendor.

G. Award of RFP Contract.

1. The vendor selected shall be qualified and best suited on the basis of the proposal and contract negotiations.

2. Price will be considered but ~~need~~ *is* not ~~be~~ *necessarily* the ~~only~~ determining factor.

3. The award document shall be a contract. It shall include requirements, terms and conditions of the RFP and the final contract terms agreed upon.

§ 4.5. Invitations for Bids.

A. A written Invitation for Bid (IFB) may be used by the department to describe in detail the specifications, contractual terms and conditions which apply to a purchase of goods or services.

B. The IFB will list special qualifications needed by a vendor. It will describe the contract requirements and set the due date for bid responses.

1. The IFB may contain inspection, testing, quality,

and other terms essential to the contract.

2. It may contain other optional data.

C. Public notice of the IFB shall be given.

1. The IFB may be mailed to potential bidders *and to the Department of Minority Business Enterprise* . In addition, it may be published in summary form stating where a full copy may be obtained in general circulation newspapers in areas where the contract will be performed. The IFB shall be posted [*for not less than five working days*] at the department's central office in a public area used to post purchase notices, and shall be given to any other interested vendor.

2. The publication of the IFB notice will consider the means which will best serve *the department's procurement needs and* competition in the private sector.

D. Receiving IFB's.

1. Bids shall be received until the date and time set forth in the IFB.

2. Late bids shall not be considered.

E. Opening IFB's.

~~Bids~~ *The IFB may provide that bids* shall be publicly opened ~~and~~ . *If bids are publicly opened,* the following items shall be read aloud:

1. Name of bidder;

2. Unit or lot price, as applicable; and

3. Terms: discount terms offered, if applicable, and brand name and model number, if requested by attendees.

F. Evaluating IFB's.

The department shall evaluate each vendor bid.

1. The evaluation shall consider whether the bid responds to the factors in the IFB.

2. All bids which respond completely to the IFB shall be evaluated to determine which bid presents the lowest dollar price.

3. The vendor presenting the lowest price bid shall be evaluated to determine whether he is a responsible bidder.

G. Award of IFB contract.

The department shall award the contract to the lowest *responsive and* responsible bidder.

§ 4.6. Sole source ~~contracts~~ *procurements* .

A. A sole source ~~contract~~ *procurement* shall be made when there is only one source *practicably* available for goods or services. *Because there is only one source practicably available, a sole source contract may be made without the use of an RFI, RFP, IFB or other competitive procurement process.*

B. *For a sole source procurement of more than $1,000 but not more than $15,000,* the ~~director~~ *department* will state in writing for the file that only one source was determined to be *practicably* available, the vendor selected, the goods or services ~~contracted~~ ~~for~~ ~~and~~ *procured,* the date of the ~~contract~~ *procurement and factors leading to the determination of sole source* .

C. ~~If~~ ~~the~~ ~~contract~~ ~~is~~ ~~over~~ ~~$10,000~~ *For a sole source procurement greater than $15,000* , on the day the director awards the ~~contract~~ *procurement* , he will post ~~the~~ [*for not less than five working days*] *a* written statement in a public area used to post purchase notices at the department's central office. *The director will state in writing for the file that only one source was determined to be practicably available, the vendor selected, the goods and services procured for* [, *the factors leading to the determination of sole source,*] *and the date of the procurement.*

§ 4.7. Emergency purchase ~~contract~~ procurement .

A. An emergency purchase ~~contract~~ *procurement* shall be made when an unexpected, sudden, serious, or urgent situation demands immediate action. *An emergency purchase may be used only to purchase goods or services necessary to meet the emergency; subsequent purchases must be obtained through normal purchasing procedures. Competitive procedures are not required to make an emergency purchase procurement.*

B. *For an emergency purchase of more than $1,000 but not more than $15,000,* the department will state in writing the nature of the emergency, the vendor selected, the goods or services ~~contracted~~ ~~for~~ ~~and~~ *procured,* the date of the ~~contract~~ *procurement and factors leading to a determination of the emergency purchase* .

C. ~~If~~ ~~the~~ ~~contract~~ ~~is~~ ~~over~~ ~~$10,000~~ *For an emergency purchase greater than $15,000* , on the day the director awards the ~~contract~~ *procurement* , ~~he~~ ~~will~~ ~~post~~ ~~the~~ *a* written statement *shall be posted* [*for not less than five working days*] in a public area used to post purchase notices at the department's central office. *The director will state in writing for the file the nature of the emergency, the vendor selected, the goods and services procured, the date of the procurement and factors leading to a determination of the emergency purchase.*

§ 4.8. Procedures for small purchases.

A. Generally.

Small purchases are those where the estimated one-time or annual contract for cost of goods or services does not exceed $15,000.

B. Price quotations.

Price quotations may be obtained through oral quotations in person or by telephone *without the use of an RFI, RFP or IFB* .

C. Written confirmation.

If the contract is $2,000 or less, no written confirmation is needed. Written price confirmation from the vendor is needed for small purchases over $2,000.

D. Except in the case of an emergency under § 4.7 *or for purchases of $1,000 or less* , the department will attempt to obtain at least three quotations.

E. In letting small purchase contracts, the department may consider factors in addition to price.

§ 4.9. *Procurement of nonprofessional services.*

A. Generally, the procurement of nonprofessional services shall be in accordance with competitive procurement principles, unless otherwise exempted.

B. Nonprofessional services may be procured through noncompetitive negotiations under the following conditions:

1. Where the estimated one-time cost is less than $5,000. When there is more that one qualified source for a specific type of nonprofessional services, every effort shall be made to utilize all such qualified sources on a rotating basis when opportunities and circumstances allow.

2. When a written determination is made and approved by the director that there is only one adequately qualifed expert or source practicably available for the services to be procured.

§ 4.10. Procurement of professional services.

A. Generally, the procurement of professional services shall be in accordance with competitive principles but is always exempt from competitive bidding requirements. Selection of professional services should be made on the basis of qualifications, resources, experience and the cost involved.

B. Professional services may be procured through noncompetitive negotiations under the following conditions:

1. Where the estimated one-time cost is less than $5,000. When there is more than one qualified source for a specific type of professional services, every effort shall be made to utilize all such qualified sources on a rotating basis when opportunities and circumstances allow.

2. When a written determination is made and approved by the director that there is only one adequately qualified professional, expert or source practicably available for the services to be procured. Such services may include those of uniquely qualified lottery industry professionals, experts or sources.

C. Professional services procurement by competitive negotiation shall be in accordance with § 4.11.

§ 4.11. Guidelines for competitive procurement of professional services.

A. In competitive negotiations for professional services, the department shall engage in one or more individual discussions with each of two or more offerors deemed fully qualified, responsible and suitable, with emphasis on professional competence to provide the required services. Such offerors shall be encouraged to elaborate on their qualifications and performance data or staff expertise pertinent to the proposed project, as well as alternative concepts. Such discussions may also include nonbinding estimates of total project costs and methods to be utilized in arriving at a price for the services.

B. At the request of an offeror, properly marked, proprietary information shall not be disclosed to the public or to competitors.

C. At the conclusion of the discussions, on the basis of predetermined evaluation factors and information developed in the selection process, the department shall select, in order of preference, two or more offerors whose professional qualifications and proposed services are deemed to meet best the department's procurement needs.

D. Negotiations are then conducted with the first ranked offeror. If a satisfactory and advantageous contract can be negotiated at a fair and reasonable price, the award is made to that offeror. Otherwise, the negotiations with the first ranked offeror are terminated formally and are conducted with the offeror ranked second and so on until such a contract can be negotiated at a fair and reasonable price.

E. If the department determines in writing and in its sole discretion that only one offeror is fully qualified, or that one offeror is clearly more highly qualified and suitable than the other offerors under consideration, a purchase may be negotiated and awarded to that offeror.

F. The department must ensure that all points negotiated are properly documented and become a part of the procurement file.

G. The department shall establish a limit for each procurement on the number of times a contract or open purchase term may be extended.

H. A contract for professional services may be made subject to the notification and public posting requirement of the formal bid procedures.

§ 4.12. Time to submit and accept RFI's, RFP's or IFB's.

A. All vendors shall submit requests for information, proposals or bids in time to reach the department before the set time and due date.

1. All vendors shall take responsibility for their chosen method of delivery to the department.

2. The department will date stamp the vendors' answers to RFI's, RFP's and IFB's when received. The department's stamped date shall be considered the official date received.

3. Any information which the department did not request or is received after the due date may be disregarded or returned to the vendor.

4. All vendors who received solicitations will be notified of any changes in the process times and dates or if a solicitation is cancelled.

B. Any proposal or bid quotation submitted by a vendor to the department shall remain valid for at least 45 days after the submission due date and will remain in effect thereafter unless the bidder retracts his bid in writing at the end of that period. The vendor must agree to accept a contract if offered within the 45-day time period. The department may require a longer or shorter period for specific goods or services.

§ ~~4.10.~~ *4.13.* Questions on bids.

Questions on contents of other bidders' bids or offerors' proposals will not be answered until after decisions are made.

§ ~~4.11.~~ *4.14.* How to modify or withdraw proposals or bids.

A. A vendor may modify or withdraw a proposal or bid before the due time and date set out in the request without any formalities except that the modification or withdrawal shall be in writing.

B. A request to modify or withdraw a bid or proposal after the due date may be given special review by the director.

1. A vendor shall put in writing and deliver to the department a statement which details how the proposal would be modified or why it should be permitted to be withdrawn.

2. A proposal or bid may be withdrawn after opening if the ~~director~~ *department* receives prompt notice and sufficient information to show that an honest error will cause undue financial loss.

C. A vendor may not modify a proposal or bid after the purchase award is made.

§ ~~4.12.~~ *4.15.* Rejection of bids.

The department reserves the right to reject any or all bids. The decision may be made that a vendor is ineligible, disqualified, not responsive or responsible, or involved in fraud, or that the best interest of the Commonwealth will not be served. Vendors so identified shall be notified in writing by the department. New bids may be requested at a time which meets the needs of the department.

§ ~~4.13.~~ *4.16.* Testing of product.

Various items or services may require testing either before or after the final award of a contract. The vendor shall guarantee price and quality before and after testing.

§ ~~4.14.~~ *4.17.* Proposal bid or performance security.

A. The department may require performance security on proposals or bids. The security is to protect the interests of the Commonwealth.

1. When required, security must be in the form of a certified check, certificate of deposit or letter of credit made payable to the State Lottery Department, or on a form issued by a surety company authorized to do business in Virginia.

2. When required, security will not be waived *, except upon action by the director .*

B. Security provided by vendors to whom a contract is awarded will be kept by the department until all provisions of the contract have been completed.

§ ~~4.15.~~ *4.18.* Assignment of contracts.

A vendor may not assign any contract to another party without permission of the director.

§ ~~4.16.~~ *4.19.* Strikes, lockouts or acts of God.

Whenever a vendor's place of business, mode of delivery or source of supply has been disrupted by a strike, lockout or act of God, the vendor will promptly advise the department by telephone and in writing. The department may cancel all orders on file with the vendor and place an order with another vendor.

§ ~~4.17.~~ *4.20.* Remedies for the department on goods and services which do not meet the contract.

A. In any case where the vendor fails to deliver, or has delivered goods or services which do not meet the contract standards, the department will send a written "Notice to Cure" to the vendor for correction of the problem.

B. If the vendor does not respond adequately to the "Notice to Cure," the department may cancel the contract and buy goods or services from another vendor. Any increase between the contract price and market price will be paid by the vendor who failed to follow the contract. This remedy shall be in addition to any other remedy provided by law.

§ ~~4.18.~~ *4.21.* Administration of contracts.

A. Generally.

The department will follow procedures in administering its contracts that will ensure that the vendor is complying with all terms and conditions of the contract.

B. Records.

The department shall keep all records relating to a contract for three years after the end of a contract.

1. The records shall include the requirements, a list of the vendors bidding, methods of evaluation, a signed copy of the contract, comments on vendor performance, and any other information necessary.

2. Records shall be open to the public except for proprietary information for which protection has been properly requested.

C. Change orders.

1. Contracts may need to be adjusted for minor changes. The department may change the contract to correct errors, to add or delete small quantities of goods, or to make other minor changes.

2. The department shall send the changes in writing to the vendor. Vendors who deviate from the contract without receiving the written changes from the department do so at their own risk.

3. Modificiations which increase the original contract price by an amount less than $5,000 may be made by letters issued by the State Lottery Department and accepted by signature of the contractor. Such letter shall become part of the official contract. In no event shall the cumulative amount of the contract increased by all such letters exceed $10,000.

4. All contract changes of $5,000 or more require a formal written amendment to the contract.

D. Cancellation orders.

The department shall cancel orders in writing. Contracts may be cancelled if the vendor fails to fulfill his obligations as provided in § ~~4.17~~ *4.20* A and B.

E. Overshipments and overruns.

The department may refuse to accept goods which exceed the number ordered. The goods may be returned to the vendor at the vendor's expense.

F. Inspection, acceptance and rejection of goods or services.

1. The department shall be responsible for inspecting, accepting or rejecting goods or services under contract.

2. In rejecting goods or services, the department will notify the vendor as soon as possible.

3. The department will state the reasons for rejecting the goods or services and request prompt replacement.

4. Replacement goods or services shall be made available at a date acceptable to the department.

G. Complaints.

The department will report complaints in writing to the vendor as they occur. The reports will be part of the department's purchase records.

H. Invoice processing.

To maintain good vendor relations and a competitive environment, the department will process invoices promptly. The department shall follow the requirements for prompt payment found in Title 11, Chapter 7, Article 2.1 of the Code of Virginia. The department will use rules and regulations issued by the Department of Accounts to process invoices.

I. Default actions.

Before the department finds a vendor in default of a contract, it will consider the specific reasons the vendor failed and the time needed to get goods or services from other vendors.

J. Termination for convenience of the department.

1. A purchase order or contract may be terminated for the convenience of the department by delivering to the vendor a notice of termination specifying the extent to which performance under the purchase order or contract is terminated, and the date of termination. After receipt of a notice of termination, the contractor must stop all work or deliveries under the purchase order or contract on the date and to the extent specified.

2. If the purchase order or contract is for commercial items sold in substantial quantities to the general public and no specific identifiable inventories were maintained exclusively for the department's use, no claims will be accepted by the department. Payment will be made for items shipped prior to receipt of the termination notice.

3. If the purchase order or contact is for items being produced exclusively for the use of the department, and raw materials or services must be secured by the vendor from other sources, the vendor shall order no additional materials or services except as may be necessary for completion of any portion of the work which was not terminated. The department may direct the delivery of the fabricated or unfabricated parts, work in process, completed work, supplies, and other material produced as a part of, or acquired in connection with the performance of the work, or direct the vendor to sell the same, subject to the department's approval as to price. The vendor may, with the approval of the department retain the same, and apply a credit to the claim. The vendor must complete performance on any part of the purchase order or contract which was not terminated.

4. Within 120 days after receipt of the notice of termination, or such longer period as the department for good cause may allow, the vendor must submit any termination claims. This claim will be in a form and with certifications prescribed by the purchasing office that issued the purchase order. The claim will be reviewed and forwarded with appropriate recommendations to the requisitioning agency or the appropriate assistant attorney general, or both, for disposition in accordance with § 2.1-127 of the Code of Virginia.

§ ~~4.10.~~ *4.22.* Vendor background. ~~not:~~

A. A vendor shall allow the department to check his background. The background check may extend to any on-line or instant ticket vendor employee working directly on a contract with the department, any parent or subsidiary corporation of the vendor and shareholders of 5.0% or more of the vendor, parent or subsidiary corporation. The check may include officers and directors of the vendor or parent or subsidiary corporation.

B. Before contracting with the department, the *department may require a* vendor ~~shall~~ *to* sign an agreement with the department to allow a criminal investigation of the entities and persons named in § ~~4.10~~ *4.22 A* .

C. The vendor shall allow the department to audit, inspect, examine or photocopy the vendor's records related to the State Lottery Department business during normal business hours.

§ ~~4.20.~~ *4.23.* Ethics in contracting.

A. Generally.

Except for more stringent requirements set forth in this section, the department will follow the ethics in public contracting requirements of the Virginia Public Procurement Act, Title 11, Chapter 7, Article 4 of the Code of Virginia.

B. Employee role with vendors prohibited.

A department employee who has responsibility to buy from vendors may not:

1. Be employed by a vendor at the same time;

2. Have a business associate or a member of his household be an officer, director, trustee, partner or hold a similar position with a vendor and play a role in soliciting contracts for vendors;

3. Himself or his business associate or a member of his household own or control an interest in a vendor of at least 5.0%;

4. Himself or his business associate or a member of his household have a financial interest in a contract procured for the department;

5. Himself or his business associate or a member of his household negotiate or have an arrangement about prospective employment with a vendor.

C. Offers, requests, or acceptance of gifts.

No vendor or employee of the department involved in purchasing will offer, request or accept, at the present or in the future, any payment, loan, advance, deposit of money, services or anything of more than nominal value for which nothing of comparable value is exchanged.

D. Kickbacks.

No vendor will demand or receive from any of his suppliers or subcontractors, as an incentive for a contract, any kickback.

E. Vendors to give certified statement on ethics in contracting.

Each vendor shall give the department a certified statement that the proposal, bid, or contract or any claim is not the result of, or affected by, collusion with another vendor. The statement will also state that no act of fraud has been involved in negotiating, signing and meeting the contract.

F. Department employees to give notice of subsequent employment with vendors.

Any department employee or former employee who dealt in an official capacity with vendors on procurement

actions who intends to accept employment from any such vendor within one year of terminating his employment with the department shall give notice to the director of his intention prior to his first day of employment with the vendor.

G. Any contract which violates the contracting ethics in the Code of Virginia and these regulations may be voided and rescinded immediately by the department.

PART V.
PROCUREMENT APPEALS AND DISPUTES.

§ 5.1. Generally.

The State Lottery Department is not subject to the Virginia Public Procurement Act or its procedures. In lieu thereof, this regulation applies to all vendors. In the event of a protest on a procurement action, the vendor shall follow the remedies available in this regulation. The vendor assumes whatever risks are involved in the selected method of delivery to the director. The director will conduct a hearing on each appeal or he shall designate a hearing officer to preside over the hearing.

§ 5.2. Appeals, protests, time frames and remedies related to solicitation and award of contracts.

A. If a vendor is considered ineligible or disqualified.

1. The vendor may appeal the department's decision. The written appeal shall be filed within 10 days after the vendor receives the department's decision.

2. If appealed and the department's decision is reversed, the sole relief will be to consider the vendor eligible for the particular contract.

B. If a vendor is not allowed to withdraw a bid in certain circumstances.

1. The vendor may appeal the department's decision. The written appeal shall be filed within 10 days after the vendor receives the department's decision.

2. If no bond has been posted by the vendor, then before appealing the department's decision the vendor shall provide to the department a certified check or cash bond for the amount of the difference between the bid sought to be withdrawn and the next lowest bid.

a. The certified check shall be payable to the State Lottery Department.

b. The cash bond shall name the State Lottery Department as obligor.

c. The security shall be released if the vendor is allowed to withdraw the bid or if the vendor withdraws the appeal and agrees to accept the bid or if the department's decision is reversed.

d. The security shall go to the State Lottery Department if the vendor loses all appeals and fails to accept the contract.

3. If appealed and the department's decision is reversed, the sole relief shall be to allow the vendor to withdraw the bid.

C. If a vendor is considered not responsible for certain contracts.

1. Any vendor, despite being the low bidder, may be determined not to be responsible for a particular contract. The vendor may appeal the department's decision. The written appeal shall be filed within 10 days after the vendor receives the department's decision.

2. If appealed and the department's decision is reversed, the sole relief shall be that the vendor is a responsible vendor for the particular contract under appeal.

3. A vendor protesting the department's decision that he is not responsible, shall appeal under this section and shall not protest the award or proposed award under subsection D.

4. Nothing contained in this subsection shall be construed to require the department to furnish a statement of the reasons why a particular proposal was not deemed acceptable.

D. If a vendor protests an award or decision.

1. Any vendor or potential vendor may protest the award or the department's decision to award a contract. The written protest shall be filed within 10 days after the award on the announcement of the decision to award is posted or published, whichever occurs first.

2. If the protest depends upon information contained in public records pertaining to the purchase, then a 10 day time limit for a protest begins to run after the records are made available to the vendor for inspection, so long as the vendor's request to inspect the records is made within 10 days after the award or the announcement of the decision to award is posted or published, whichever occurs first.

3. No protest can be made that the selected vendor is not a responsible vendor. The only grounds for filing a protest are (i) that a procurement action was not based upon competitive principles, or (ii) that a procurement action violated the standards of ethics promulgated by the board.

4. If, prior to an award, it is determined by the

director that the department's decision to award the contract is erroneous, the only relief will be that the director will cancel the proposed award or revise it.

5. No protest shall delay the award of a contract.

6. Where the award has been made, but the work has not begun, the director may stop the contract. Where the award has been made and the work begun, the director may decide that the contract is void if voiding the contract is in the best interest of the public. Where a contract is declared void, the performing vendor will be paid for the cost of work up to the time when the contract was voided. In no event shall the performing vendor be paid for lost profits.

§ 5.3. Appeals, time frames and remedies related to contract disputes and claims.

A. Generally.

In the event a vendor has a dispute with the department over a contract awarded to him, he may file a written claim with the director.

B. Contract claims.

Claims for money or other relief, shall be submitted in writing to the director, and shall state the reasons for the action.

1. All vendor's claims shall be filed no later than 30 days after final payment is made by the department.

2. If a claim arises while a contract is still being fulfilled, a vendor shall give a written notice of the vendor's intention to file a claim. The notice shall be given to the director at the time the vendor begins the disputed work or within 10 days after the dispute occurs.

3. Nothing in this regulation shall keep a vendor from submitting an invoice to the department for final payment after the work is completed and accepted.

4. Pending claims shall not delay payment from the department to the vendor for undisputed amounts.

5. The director's decision will state the reasons for the action.

C. Claims relief.

Relief from administrative procedures, liquidated damages, or informalities may be given by the director. The circumstances allowing relief usually result from acts of God, sabotage, and accidents, fire or explosion not caused by negligence.

§ 5.4. Form and content of appeal to the director.

A. Form for appeal.

The vendor shall make the appeal to the director in writing. The appeal shall be mailed to the State Lottery Director, State Lottery Department, P.O. Box 4689, Richmond, Virginia 23220 or hand delivered to the department's central office at the Bookbindery Building, 2201 West Broad Street, Richmond, Virginia 23220.

B. Content of appeal.

The appeal shall state the:

1. Decision of the department which is being appealed;

2. Basis for the appeal;

3. Contract number;

4. Other information which identifies the contract; and

5. Reasons for the action.

C. Vendor notification.

The director's decision on an appeal will be sent to the vendor by registered mail, return receipt requested.

1. The director shall follow the time limits in the regulations and shall not make exceptions to the filing periods for the vendor's appeal and rendering the director's decision.

2. The director's decision will state the reasons for the action.

§ 5.5. State Lottery Department appeal hearing procedures.

A. Generally.

The director or the appointed hearing officer will conduct a hearing on every appeal within 45 days after the appeal is filed with the director. The hearings before the State Lottery Department are not trials and shall not be conducted like a trial.

1. The Administrative Process Act does not apply to the hearings.

2. The hearings shall be informal. The vendor and the department will be given a reasonable time to present their position.

3. Legal counsel may represent the vendor or the department. Counsel is not required.

4. The director may exclude evidence which he determines is repetitive or not relevant to the dispute under consideration.

5. The director may limit the number of witnesses, testimony and oral presentation in order to hear the appeal in a reasonable amount of time.

6. Witnesses may be asked to testify. The director does not have subpoena power. No oath will be given.

7. The director may ask questions at any time. The director may not question the vendor in closed session.

B. Public hearings for appeals.

1. Hearings shall be open to the public. The director may adjourn the public hearing to discuss and reach his decision in private.

2. The hearings shall be electronically recorded. The department will keep the recordings for 60 days.

3. A court reporter may be used. The court reporter shall be paid by the person who requested him.

a. The court reporter's transcript shall be given to the director at no expense, unless the director requests the use of a court reporter.

b. The transcript shall become part of the department's records.

C. Order during the hearing.

Unless the director determines otherwise, hearings will be in the following order:

1. The vendor will explain his reasons for appealing and the desired relief.

2. The vendor will present his witnesses and evidence. The director and the department will be able to ask questions of each witness.

3. The department will present its witnesses and evidence. The appellant may ask questions of each party and witness.

4. After all evidence has been presented, the director shall reach his decision in private.

§ 5.6. Notice, time and place of hearings.

A. Notice and setting the time.

All people involved in the hearing will be given at least 10 days notice of the time and place of the appeal hearing.

1. Appeals may be heard sooner if everyone agrees.

2. In scheduling hearings, the director may consider the desires of the people involved in the hearing.

B. Place of hearings.

All hearings shall be held in Richmond, Virginia, unless the director decides otherwise.

§ 5.7. Who may take part in the appeal hearing.

A. Generally.

The director may request specific people to take part in the hearing.

B. Hearings on ineligibility, disqualification, responsibility or denial of a request to withdraw a bid.

The protesting vendor and the department shall participate.

C. Hearings on claims or disputes.

The protesting vendor and the department shall participate.

§ 5.8. Director's decision.

A. Generally.

The director will issue a written decision within 30 days after the hearing date except for hearings with a court reporter.

B. Hearings with court reporter.

For hearings with a court reporter, the director's decision will be issued within 30 days after a transcript of the hearing is received by the director if a transcript is prepared. There is no requirement that a transcript be made, even if services of a court reporter are used for the hearing.

C. Format of decision.

1. The director's decision will include a brief statement of the facts. This will be called "Findings of Fact."

2. The director will give his decision. The decision will include as much detail as the director feels is necessary to set out reasons for his decision.

3. The decision will be signed by the director.

D. Copies of the decision.

Copies will be mailed to the appealing vendor, all other vendors who participated in the appeal and the department. The director will give copies of the decision to other people who request it.

§ 5.9. Appeal to courts.

A. The department is not subject to the Virginia Public Procurement Act. Thus, a vendor has no automatic right of appeal of a decision to award, an award, a contract dispute, or a claim with the department.

B. Nothing in these regulations shall prevent the director from taking legal action against a vendor.

* * * *

NOTICE: The forms used in administering the Administration Regulations are not being published; however, the name of each form is listed below. The forms are available for public inspection at the State Lottery Department, 2201 West Broad Street, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Informal Administrative Hearing Request
Formal Administrative Hearing Request
State Lottery Department - Agency Purchase Order

* * * * * * * *

Title of Regulation: **VR 447-02-1. Instant Game Regulations.**

Statutory Authority: § 58.1-4007 of the Code of Virginia.

Effective Date: April 24, 1991.

Summary:

The State Lottery Department is amending sections of the Instant Game Regulations which established procedures specifically related to instant lottery games, including standards and requirements for licensing retailers, specific operational parameters for the conduct of the game, instant ticket validation requirements and payment of prizes.

The regulations amend several major portions of these regulations: (i) expands standards for licensing to include a requirement that the retailer have the ability to offer high levels of customer service, including the ability to display point of sale material, a favorable image, the ability to pay prizes during maximum selling hours, and a commitment to authorize employees to participate in lottery training; (ii) changes the term of licensure from annual to perpetual, subject to an annual review of retailer eligibility and the payment of an annual fee, approved earlier as an emergency regulation; (iii) expands conditions under which the director may refuse to issue and to continue a license; (iv) waives service charges, interest and penalties if a late payment by a lottery retailer is caused by a bank or by the department; and (v) authorizes acceptance of a photocopy of the ticket for prize payment under certain circumstances.

Subsequent to publication of the regulations in proposed form, a revision was made to § 2.8 regarding licensed retailers' compensation. Current regulations require inclusion of any approved lottery retailer incentive or bonus program in the rules to the specific lottery game to which it applies. Frequently, the incentive programs apply to more than one lottery game and, occasionally, to the lottery games previously adopted and being sold. Therefore, rules from each of the prior games would have to be revised. Because the purpose of including the programs in the rules is for public notice, the same result can be achieved by issuing a Director's Order which is similarly published.

VR 447-02-1. Instant Game Regulations.

PART I.
LICENSING OF RETAILERS FOR INSTANT GAMES.

§ 1.1. Licensing.

Generally.

The director may license as lottery retailers for instant games persons who will best serve the public convenience and promote the sale of tickets and who meet the eligibility criteria and standards for licensing.

For purposes of this part on licensing, "person" means an individual, association, partnership, corporation, club, trust, estate, society, company, joint stock company, receiver, trustee, assignee, referee, or any other person acting in a fiduciary or representative capacity, whether appointed by a court or otherwise, and any combination of individuals. "Person" also means all departments, commissions, agencies and instrumentalities of the Commonwealth, including its counties, cities, and towns.

§ 1.2. Eligibility.

A. Eighteen years of age and bondable.

Any person who is 18 years of age or older and who is bondable may submit an application for licensure, except no person may submit an application for licensure:

1. Who will be engaged ~~solely~~ *primarily* in the business of selling lottery tickets; or

2. Who is a board member, officer or employee of the State Lottery Department or who resides in the same household as a board member, officer or employee of the department; or

3. Who is a vendor of lottery tickets or material or data processing services, or whose business is owned by, controlled by, or affiliated with a vendor of lottery tickets or materials or data processing services.

B. Application not an entitlement to license.

The submission of an application for licensure does not in any way entitle any person to receive a license to act as a lottery retailer.

§ 1.3. Application procedure.

Filing of forms with the department.

Any eligible person shall first file an application with the department on forms supplied for that purpose, along with the required fees as specified elsewhere in these regulations. The applicant shall complete all information on the application forms in order to be considered for licensing. The forms to be submitted include:

1. Retailer License Application;

2. Personal Data Form(s); and

3. ~~Preliminary~~ ~~Marketing~~ ~~Evaluation~~ *Retailer Location* Form.

State Lottery Law makes falsification, concealment or misrepresentation of a material fact, or making a false, fictitious or fraudulent statement or representation in an application for a license a misdemeanor.

§ 1.4. General standards for licensing.

A. Selection factors for licensing.

The director may license those persons who, in his opinion, will best serve the public interest and public trust in the lottery and promote the sale of lottery tickets. The director will consider the following factors before issuing or renewing a license:

1. The financial responsibility and security of the applicant, to include:

a. A credit and criminal background investigation;

b. Outstanding state tax liability;

c. Required business licenses, tax and business permits;

d. Physical security at the place of business, including insurance coverage.

2. The accessibility of his place of business to the public, to include:

a. The hours of operation;

b. The availability of parking and transit routes, where applicable;

c. The location in relation to major employers, schools, or retail centers;

d. The population level and rate of growth in the market area;

e. The traffic density, including levels of congestion in the market area.

3. The sufficiency of existing lottery retailers to serve the public convenience, to include:

a. The number of and proximity to other lottery retailers in the market area;

b. The expected sales volume and profitability of potentially competing lottery retailers;

c. The adequacy of coverage of all regions of the Commonwealth with lottery retailers.

4. The volume of expected lottery ticket sales, to include:

a. Type and volume of the products and services sold by the retailer;

b. Dollar sales volume of business;

c. Sales history of business and market area;

d. Volume of customer traffic in place of business.

5. The ability to offer high levels of customer service to instant lottery players, to include:

a. Ability to display point of sale material;

b. A favorable image consistent with lottery standards;

c. Ability to pay prizes during maximum selling hours; and

d. Commitment to authorize employee participation in all required instant lottery training.

B. Additional factors for selection.

The director may develop and, by administrative order, publish additional criteria which, in his judgment, are necessary to serve the public interest and public trust in the lottery.

§ 1.5. Bonding of lottery retailers.

A. Approved retailer to secure bond.

A lottery retailer approved for licensing shall obtain a surety bond from a surety company entitled to do business in Virginia. The purpose of the surety bond is to protect the Commonwealth from a potential loss in the event the retailer fails to perform his responsibilities.

1. Unless otherwise provided under subsection C of this section, the surety bond shall be in the amount and penalty of $5,000 and shall be payable to the State Lottery Department and conditioned upon the faithful performance of the lottery retailer's duties.

2. Within 15 calendar days of receipt of the "License Approval Notice," the lottery retailer shall return the properly executed "Bonding Requirement" portion of the "License Approval Notice" to the State Lottery Department to be filed with his record.

B. Continuation of surety bond on ~~renewal of~~ *annual* license *review* .

A lottery retailer ~~applying for renewal of a license~~ *whose license is being reviewed* shall:

1. Obtain a letter or certificate from the surety company to verify that the surety bond is being continued for the *annual* license ~~renewal~~ *review* period; and

2. Submit the surety company's letter or certificate with the required *annual* license ~~renewal~~ fee to the State Lottery Department.

C. Sliding scale for surety bond amounts.

The department may establish a sliding scale for surety bonding requirements based on the average volume of lottery ticket sales by a retailer to ensure that the Commonwealth's interest in tickets to be sold by a licensed lottery retailer is adequately safeguarded.

D. Effective date for sliding scale.

The sliding scale for surety bonding requirements will become effective when the director determines that sufficient data on lottery retailer ticket sales volume activity are available. Any changes in a retailer's surety bonding requirements that result from instituting the sliding scale will become effective only at the time of the retailer's next ~~renewal~~ *annual license review* action.

§ 1.6. Lottery bank accounts and EFT authorization.

A. Approved retailer to establish lottery bank account.

A lottery retailer approved for licensing shall establish a separate bank account to be used exclusively for lottery business in a bank participating in the Automatic Clearing House (ACH) system.

B. Retailer's use of lottery account.

The lottery account will be used by the retailer to make funds available to permit withdrawals and deposits initiated by the department through the electronic funds transfer (EFT) process to settle a retailer's account for funds owed or due from the purchase of tickets and the payment of prizes. All retailers shall make payments to the department through the electronic funds transfer (EFT) process unless the director designates another form of payment and settlement under terms and conditions he deems appropriate.

C. Retailer responsible for bank charges.

The retailer shall be responsible for payment of any fees or service charges assessed by the bank for maintaining the required account.

D. Retailer to authorize electronic funds transfer.

Within 15 calendar days of receipt of the "License Approval Notice," the lottery retailer shall return the properly executed "Electronic Funds Transfer Authorization" portion of the "License Approval Notice" to the department to record establishment of his account.

E. Change in retailer's bank account.

If a retailer finds it necessary to change his bank account from one bank to another, he must submit a newly executed "Electronic Funds Transfer Authorization" form for the new bank account. The retailer may not discontinue use of his previously approved bank account until he receives notice from the department that the new account is approved for use.

F. Director to establish EFT account settlement schedule.

The director will establish a schedule for processing the EFT transactions against retailers' lottery bank accounts and issue instructions to retailers on how settlement of accounts will be made.

§ 1.7. License term and ~~renewal~~ *annual review* .

A. License term.

A general license for an approved lottery retailer shall be issued ~~for a one-year period~~ *on a perpetual basis subject to an annual determination of continued retailer eligibility and the payment of an annual fee fixed by the board* .

B. ~~License renewal.~~ *Annual license review.*

~~A general license shall be renewed annually at least 30 days before its expiration date and shall be accompanied by the appropriate fee(s) as specified elsewhere in these regulations.~~ *The annual fee shall be collected within the 30 days preceding a retailer's anniversary date. Upon receipt of the annual fee, the general license shall be continued so long as all eligibility requirements are met.* The director may implement a staggered, monthly basis for annual license ~~renewals~~ *reviews* and allow for the proration of annual license fees ~~to credit licensees for the time remaining on their current license when the~~

~~staggered renewal requirement is imposed~~ . This section shall not be deemed to allow for a refund of license fees when a license is terminated, revoked or suspended for any other reason.

C. ~~Temporary license.~~ *(Reserved.)*

~~No temporary licenses shall be issued after November 30, 1988.~~

~~1. All temporary licenses expire not later than December 1, 1988.~~

~~2. Upon expiration of a temporary license, the applicant shall stop the sale of tickets and surrender to a department representative his temporary license and department property and make settlement of his lottery account.~~

D. Amended license term.

~~An amended license issued under the requirements of § 1.9 C shall be valid for the remainder of the period of the license it replaces.~~ *The annual fee for an amended license issued under the requirements of § 1.9 C will be due on the same date as the fee for the license it replaced.*

E. Special license.

The director may issue special licenses to persons for specific events and activities. Special licenses shall be for a limited duration and under terms and conditions that he determines appropriate to serve the public interest.

§ 1.8. License fees.

A. License application fee.

The fee for a license application for a lottery retailer general license to sell instant game tickets shall be $25. The general license fee to sell instant game tickets shall be paid for each location to be licensed. This fee is nonrefundable.

B. *Annual* license ~~renewal~~ fee.

The annual fee for ~~renewal of~~ a lottery retailer general license to sell instant game tickets shall be an amount fixed by the board at its November meeting for all ~~renewals~~ *annual license reviews* occurring in the next calendar year. The ~~renewal~~ fee shall be designed to recover all or a portion of the annual costs of the department in providing services to the retailer. The ~~renewal~~ fee shall be paid for each location for which a license is ~~renewed~~ *reviewed* . This fee is nonrefundable. The ~~renewal~~ fee shall be submitted ~~at least~~ *within the* 30 days ~~before~~ *preceding* a retailer's ~~general license expires~~ *anniversary date* .

C. Amended license application fee.

The fee for processing an amended license application for a lottery retailer general license shall be an amount as approved by the board at its November meeting for all amendments occurring in the next calendar year. The amended license fee shall be paid for each location affected. This fee is nonrefundable. An amended license application shall be submitted in cases where a business change occurs as specified in § 1.9 B.

§ 1.9. Transfer of license prohibited; invalidation of license.

A. License not transferrable.

A license issued by the director authorizes a specified person to act as a lottery retailer at a specified location as set out in the license. The license is not transferrable to any other person or location.

B. License invalidated.

A license shall become invalid for any of the following reasons:

1. Change in business location;

2. Change in business structure (e.g., from a partnership to a sole proprietorship);

3. Change in the business owners listed in the original application form for which submission of a Personal Data Form is required under the license application procedure.

C. Amended application required.

A licensed lottery retailer who anticipates a change as listed in subsection B shall notify the department of the anticipated change at least 15 calendar days before it takes place and submit an amended application. The director shall review the changed factors in the same manner that would be required for a review of an original application.

§ 1.10. Display of license.

License displayed in general view.

Every licensed lottery retailer shall conspicuously display his lottery license in an area visible to the general public where lottery tickets are sold.

§ 1.11. Denial, suspension, revocation or ~~nonrenewal~~ *noncontinuation* of license.

A. Grounds for refusal to license.

The director may refuse to issue a license to a person if the person ~~has been~~ *does not meet the eligibility criteria and standards for licensing as set out in these regulations or if* :

1. *The person has been* convicted of a felony;

2. *The person has been* convicted of a crime involving moral turpitude;

3. *The person has been* convicted of any fraud or misrepresentation in any connection;

4. *The person has been* convicted of bookmaking or other forms of illegal gambling ~~.~~ ;

5. The person's place of business caters to or is frequented predominantly by persons under the age of 18 years of age;

6. The nature of the person's business constitutes a threat to the health or safety of prospective lottery patrons;

7. The nature of the person's business is not consonant with the probity of the Commonwealth; or

8. The person has committed any act of fraud, deceit, misrepresentation, or conduct prejudicial to public confidence in the state lottery.

B. Grounds for refusal to license partnership or corporation.

The director may refuse to issue a license to any partnership or corporation if he finds that any general or limited partner or officer or director of the partnership or corporation *does not meet the eligibility criteria and standards for licensing as set out in these regulations or if any general or limited partner or officer or director of the partnership or corporation* has been convicted of any of the offenses cited in subsection A.

C. Grounds for suspension, revocation or refusal to ~~renew~~ *continue* license.

~~After notice and a hearing,~~ The director may suspend, revoke, or refuse to ~~renew~~ *continue* a license for any of the following reasons:

1. Failure to properly account for lottery tickets received, for prizes claimed and paid or for the proceeds of the sale of lottery tickets;

2. Failure to file or maintain the required bond or the required lottery bank account;

3. Failure to comply with applicable laws, instructions, terms and conditions of the license, or rules and regulations of the department concerning the licensed activity, especially with regard to the prompt payment of claims;

4. Conviction, following the approval of the license, of any of the offenses cited in subsection A;

5. Failure to file any return or report or to keep records or to pay any fees or other charges as required by the state lottery law or the rules and regulations of the department;

6. Commission of any act of fraud, deceit, misrepresentation, or conduct prejudicial to public confidence in the state lottery;

7. Failure to maintain lottery ticket sales at a level sufficient to meet the department's administrative costs for servicing the retailer, provided that the public convenience is adequately served by other retailers;

8. Failure to notify the department of a material change, after the license is issued, of any matter required to be considered by the director in the licensing application process;

9. Failure to comply with lottery game rules;

10. Failure to meet minimum point of sale standards ~~.~~ ;

11. The person's place of business caters to or is frequented predominantly by persons under 18 years of age;

12. The nature of the person's business constitutes a threat to the health or safety of prospective lottery patrons; or

13. The nature of the person's business is not consonant with the probity of the Commonwealth.

D. Notice of intent to suspend, revoke or deny ~~renewal~~ *continuation* of license.

Before taking action under subsection C, the director will notify the retailer in writing of his intent to suspend, revoke or deny ~~renewal~~ *continuation* of the license. The notification will include the reason or reasons for the proposed action and will provide the retailer with the procedures for requesting a hearing before the board. Such notice shall be given to the retailer at least 14 calendar days prior to the effective date of suspension, revocation or denial.

E. Temporary suspension without notice.

If the director deems it necessary in order to serve the public interest and maintain public trust in the lottery, he may temporarily suspend a license without first notifying the retailer. Such suspension will be in effect until any prosecution, hearing or investigation into possible violations is concluded.

F. Surrender of license and lottery property upon revocation or suspension.

A retailer shall surrender his license to the director by

the date specified in the notice of revocation or suspension. The retailer shall also surrender the lottery property in his possession and give a final lottery accounting of his lottery activities by the date specified by the director.

§ 1.12. Responsibility of lottery retailers.

Each retailer shall comply with all applicable state and federal laws, rules and regulations of the department, license terms and conditions, specific rules for all applicable lottery games, and directives and instructions which may be issued by the director.

§ 1.13. Display of material.

A. Material in general view.

Lottery retailers shall display lottery point-of-sale material provided by the director in a manner which is readily seen by and available to the public.

B. Prior approval for retailer-sponsored material.

A lottery retailer may use or display his own promotional and point-of-sale material, provided it has been submitted to and approved for use by the department in accordance with instructions issued by the director.

C. Removal of unapproved material.

The director may require removal of any retailer's lottery material that has not been approved for use by the department.

§ 1.14. Inspection of premises.

Access to premises by department.

Each lottery retailer shall provide access during normal business hours or at such other times as may be required by the director or state lottery representatives to enter the premises of the licensed retailer. The premises include the licensed location where lottery tickets are sold or any other location under the control of the licensed retailer where the director may have good cause to believe lottery materials or tickets are stored or kept in order to inspect the lottery materials or tickets and the licensed premises.

§ 1.15. Examination of records; seizure of records.

A. Inspection, auditing or copying of records.

Each lottery retailer shall make all books and records pertaining to his lottery activities available for inspection, auditing or copying as required by the director between the hours of 8 a.m. and 5 p.m., Mondays through Fridays and during the normal business hours of the licensed retailer.

B. Records subject to seizure.

All books and records pertaining to the licensed retailer's lottery activities may be seized with good cause by the director without prior notice.

§ 1.16. Audit of records.

The director may require a lottery retailer to submit to the department an audit report conducted by an independent certified public accountant on the licensed retailer's lottery activities. The retailer shall be responsible for the cost of only the first such audit in any one license term.

§ 1.17. Reporting requirements and settlement procedures.

Instructions for purchasing tickets, reporting transactions and settling accounts.

Before a retailer may begin lottery sales, the director will issue to him instructions and report forms that specify the procedures for (i) ordering tickets; (ii) paying for tickets purchased; (iii) reporting receipts, transactions and disbursements pertaining to lottery ticket sales; and (iv) settling the retailer's account with the department.

§ 1.18. Deposit of lottery receipts; interest and penalty for late payment; dishonored EFT transfers or checks.

A. Forms of payment for tickets; deposit of lottery receipts.

Each lottery retailer shall purchase the tickets distributed to him. The moneys for payment of these tickets shall be deposited to the credit of the State Lottery Fund by the department. The retailer shall make payments to the department by Electronic Funds Transfers (EFT); however, the director reserves the right to specify one or more of the following alternative forms of payment under such conditions as he deems appropriate:

1. Cash;

2. Cashier's check;

3. Certified check;

4. Money order; or

5. Business check.

B. Payment due date.

Payments shall be due as specified by the director in the instructions to retailers regarding the purchasing and payment of tickets and the settlement of accounts.

C. Penalty and interest charge for late payment.

Any retailer who fails to make payment when payment is due will be assessed an interest charge on the moneys due plus a $25 penalty. The interest charge will be equal

to the "Underpayment Rate" established pursuant to § 6621(a)(2) of the Internal Revenue Code of 1954, as amended. The interest charge will be calculated beginning the date following the retailer's due date for payment through the day preceding receipt of the late payment by the department for deposit.

D. Service charge for dishonored EFT transfer or bad check.

The director will assess a service charge of $25 against any retailer whose payment through electronic funds transfer (EFT) or by check is dishonored.

E. Service charge for debts referred for collection.

If the department refers a debt of any retailer to the Attorney General, the Department of Taxation or any other central collection unit of the Commonwealth, the retailer owing the debt shall be liable for an additional service charge which shall be in the amount of the administrative costs associated with the collection of the debt that are incurred by the department and the agencies to which the debt is referred.

F. Service charge, interest and penalty waived.

The service charge, interest and penalty charges may be waived when the event which would otherwise cause a service charge, interest or penalty to be assessed is not in any way the fault of the lottery retailer. For example, a waiver may be granted in the event of a bank error or lottery error.

§ 1.19. Training of retailers and their employees.

Retailer training.

Each retailer or his designated representative or representatives is required to participate in training given by the department in the operation of each game. The director may consider nonparticipation as grounds for suspending or revoking the retailer's license.

§ 1.20. License termination by retailer.

Voluntary termination of license.

The licensed retailer may voluntarily terminate his license with the department by first notifying the department in writing at least 15 calendar days before the proposed termination date. The department will then notify the retailer of the date by which settlement of the retailer's account will take place. The retailer shall maintain his bond and the required accounts and records until settlement is completed and all lottery property belonging to the department has been surrendered.

PART II.
INSTANT GAMES.

§ 2.1. Development of instant games.

The director shall select, operate, and contract for the operation of instant games which meet the general criteria set forth in these regulations. The board shall determine the specific details of each instant game after consultation with the director. These details include, but are not limited to:

1. Prize amounts and prize structure,

2. Types of noncash prizes, if any, and

3. The amount and type of any jackpot or grand prize which may be awarded.

§ 2.2. Prize structure.

The prize structure for any instant game shall be designed to return to winners approximately 50% of gross sales.

A. The specific prize structure for each instant game shall be approved in advance by the board.

B. Prizes may be cash or noncash awards, including instant game tickets.

§ 2.3. Ticket price.

A. The sale price of a lottery ticket for each game will be determined by the board ~~and will be between $.25 and $15~~ . Lottery retailers may not discount the sale price of instant game tickets or offer free tickets as a promotion with the sale of instant tickets. This section shall not prevent a retailer from providing free instant tickets with the purchase of other goods or services customarily offered for sale at the retailer's place of business; provided, however, that such promotion shall not be for the primary purpose of inducing persons to participate in the lottery.

B. This section shall not apply to the redemption of a winning instant ticket the prize for which is another free ticket.

§ 2.4. Sales, gift of tickets to minors prohibited.

An instant game ticket shall not be sold to, purchased by, *redeemed from* or given as a gift to any individual under 18 years old.

§ 2.5. Odds of winning.

The director shall publicize the overall odds of winning a prize in each instant game. The odds may be printed on the ticket or contained in informational materials, or both.

§ 2.6. End of game.

Each instant game will end ~~when all tickets have been~~

~~sold or~~ on a date announced in advance by the director. The director may suspend or terminate an instant game without advance notice if he finds that this action will serve and protect the public interest.

§ 2.7. Sale of tickets from expired games prohibited.

No instant game tickets shall be sold after that game ends.

§ 2.8. Licensed retailers' compensation.

A. Licensed retailers shall receive 5.0% compensation on all instant game tickets purchased from the department for resale by the retailer.

B. The director may award cash bonuses or other incentives to retailers. The board shall approve any bonus or incentive system. The director will publicize any such system [~~in rules of the game(s) to which it applies~~ *by administrative order*].

§ 2.9. Price for ticket packs.

For each pack, retailers shall pay the retail value, less the 5.0% retailer ~~discount~~ *compensation* and less the value of the low-tier winning tickets in the pack. For example, for a pack of tickets with a retail value of $500, and guaranteed low end prize structure of $165, the retailer would pay $310: $500 (the pack value) minus $165 for low-tier winners, less the retailer's $25 ~~discount~~ *compensation* .

§ 2.10. Purchase of instant tickets.

A. Retailers shall purchase books of tickets directly from the department or through designated depositories.

B. Retailers shall pay for tickets via an electronic funds transfer (EFT) initiated by the department.

1. The department will initiate the EFT after tickets are delivered to the retailer. The schedule will be determined by the director.

2. If ~~, for any reason,~~ an electronic funds transfer is refused, the retailer shall be assessed service charge, interest and penalty charges as provided for in these regulations. *The service charge, interest and penalty charges may be waived under § 1.18 F of these regulations.*

3. The director may approve another form of payment for designated retailers under conditions to be determined by the director.

4. If the director permits payment by check and if payment on any check is denied, the retailer shall be assessed service charge, interest and penalty charges as provided for in these regulations.

C. Once tickets are accepted by a retailer, the department will not replace mutilated or damaged tickets, unless specifically authorized by the director.

D. Ticket sales to retailers are final.

1. The department will not accept returned tickets except as provided for elsewhere in these regulations or with the director's advance approval.

2. The retailer is responsible for lost, stolen or destroyed tickets unless otherwise approved by the director.

§ 2.11. Retailers' conduct.

A. Retailers shall sell instant tickets at the price fixed by regulation, unless the board allows reduced prices or ticket give-aways.

B. All ticket sales shall be for cash, check, cashier's check, traveler's check or money order at the discretion of and in accordance with the licensed retailer's policy for accepting payment by such means. A ticket shall not be purchased with credit cards, food stamps or food coupons.

C. All ticket sales shall be final. Retailers shall not accept ticket returns except as allowed by department regulations or policies or with the department's specific approval.

D. Tickets shall be sold during all normal business hours unless the director approves otherwise.

E. Tickets shall be sold only at the location listed on each retailer's license from the department.

F. Retailers shall not sell instant tickets after the announced end of an instant game.

G. Retailers shall not break apart ticket packs to sell instant tickets except to sell tickets from the same pack at separate selling stations within the same business establishment.

H. Retailers shall not exchange ticket books or tickets with one another or sell ticket books or tickets to one another.

I. On the back of each instant ticket sold by a retailer, the retailer shall print or stamp the retailer's name, address and retailer number. This shall be done in a manner that does not conceal any of the preprinted material.

J. No retailer or his employee or agent shall try to determine the numbers or symbols appearing under the removable latex coverings or otherwise attempt to identify unsold winning tickets. However, this shall not prevent the removal of the covering over the validation code or validation number after the ticket is sold and a prize is

claimed.

K. Unsupervised retailer employees who sell or otherwise vend lottery tickets must be at least 18 years of age. Employees not yet 18 but at least 16 years of age may sell or vend lottery tickets so long as they are supervised by a person 18 years of age or older.

§ 2.12. Returns of unsold tickets.

A. Each retailer may return for credit full, unbroken ticket packs to the department at any time before the announced end of the game and before the return of any partial packs.

B. After the twelfth week of any instant game, each retailer may return broken partial packs of tickets to the department for credit. Partial pack returns are limited to one pack return per register where tickets have been sold for that game. At the same time partial packs are returned, the retailer must return all eligible partial packs and all full packs for that game remaining in his inventory. No additional partial packs or full packs will be accepted from the retailer by the department for credit after partial packs have been returned.

C. All tickets in the possession of a retailer remaining unsold at the announced end of the game, the return of which are not prohibited by § 2.12 B, whether partial pack or full pack, must be returned to the department not later than 21 calendar days after the announced end of each instant game or any final prize drawing or no credit will be allowed to the retailer for tickets remaining unsold by that retailer.

§ 2.13. Reserved.

§ 2.14. Reserved.

§ 2.15. Reserved.

PART III.
PAYMENT OF PRIZES FOR INSTANT GAMES.

§ 3.1. Prize winning tickets.

Prize-winning instant tickets are those that have been validated and determined in accordance with the rules of the department to be official prize winners. Consistent with these regulations, criteria and specific rules for winning prizes shall be published and posted by the director for each instant game and made available for all players. Final validation and determination of prize winning tickets remains with the department.

§ 3.2. Unclaimed prizes.

All instant game winning tickets shall be received for payment as prescribed in these regulations within 180 days after the announced end of the game or of the event which caused the ticket to be a winning entry, whichever is later. In the event that the 180th day falls on a Saturday, Sunday or legal holiday, a claimant may redeem his prize-winning ticket on the next business day. Tickets which have been mailed in an envelope bearing a postmark on or before the 180th day will be deemed to have been received on time.

A. Any non-low-tier instant game prize which has been won as a result of a drawing but which is not claimed within 180 days after the instant game drawing shall revert to the State Literary Fund.

B. Any non-low-tier instant game *cash* prize which has been won other than by drawing, but which is not claimed within 180 days after the announced end of the instant game shall revert to the State Literary Fund.

C. Any instant game low-tier prize-winning ticket which has been purchased but which is not claimed within 180 days after the announced end of the instant game shall revert as a bonus compensation to the account of the retailer which sold the instant game low-tier prize-winning ticket.

§ 3.3. Using winners' names.

The department shall have the right to use the names of prize winners. Photographs of prize winners may be used with the written permission of the winners. No additional consideration shall be paid by the department for this purpose.

§ 3.4. No prize paid to people under 18.

No prize shall be claimed by , *redeemed from* or paid to any individual under 18 years of age.

§ 3.5. Where prizes claimed.

Winners may claim instant game prizes from the retailer from whom the ticket was purchased or the department in the manner specified in these regulations.

§ 3.6. Validating winning tickets.

Winning tickets shall be validated by the retailer or the department as set out in these regulations or in any other manner which the director may determine.

§ 3.7. How prize claim entered.

A prize claim shall be entered in the name of an individual person or legal entity. If the prize claimed is $600 or greater, the person or entity also shall furnish a tax identification number.

A. An individual shall provide his social security number if a claim form is required by these regulations.

B. A claim may be entered in the name of an organization only if the organization is a legal entity and

possesses a federal employer's identification number (FEIN) issued by the Internal Revenue Service.

1. If the department, a retailer or these regulations require that a claim form be filed, the FEIN shall be shown on the claim form.

2. A group, family unit, club or other organization which is not a legal entity or which does not possess a FEIN may file Internal Revenue Service (IRS) Form 5754, "Statement by Person(s) Receiving Gambling Winnings," with the department. This form designates to whom winnings are to be paid and the person(s) to whom winnings are taxable.

3. A group, family unit, club or other organization which is not a legal entity or which does not possess a FEIN and which does not file IRS Form 5754 with the department shall designate one individual in whose name the claim shall be entered and that person's social security number shall be furnished.

§ 3.8. Right to prize not assignable.

No right of any person to a prize shall be assignable, except that:

1. The director may pay any prize to the estate of a deceased prize winner, and

2. The prize to which a winner is entitled may be paid to another person pursuant to an appropriate judicial order.

§ 3.9. No accelerated payments.

The director shall not accelerate payment of a prize for any reason.

§ 3.10. Liability ends with prize payment.

All liability of the Commonwealth, its officials, officers and employees, and of the department, the director and employees of the department, terminates upon payment of a lottery prize.

§ 3.11. Delay of payment allowed.

The director ~~or the board~~ may refrain from making payment of the prize pending a final determination by the director under any of the following circumstances:

1. If a dispute occurs or it appears that a dispute may occur relative to any prize;

2. If there is any question regarding the identity of the claimant;

3. If there is any question regarding the validity of any ticket presented for payment; or

4. If the claim is subject to any set off for delinquent debts owed to any agency eligible to participate in the Set-Off Debt Collection Act.

No liability for interest for such delay shall accrue to the benefit of the claimant pending payment of the claim.

§ 3.12. When periodic prize payment may be delayed.

The director may, at any time, delay any payment in order to review a change in circumstance relative to the prize awarded, the payee, the claim, or any other matter that has been brought to the department's attention. All delayed payments shall be brought up to date immediately upon the director's confirmation. Delayed payments shall continue to be paid according to the original payment schedule after the director's decision is given.

§ 3.13. Ticket is bearer instrument.

A ticket that has been legally issued by a lottery retailer is a bearer instrument until the ticket has been signed. The person who signs the ticket is considered the bearer of the ticket.

§ 3.14. Payment made to bearer.

Payment of any prize will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification and the submission of a prize claim form if one is required, unless otherwise delayed in accordance with these regulations.

§ 3.15. Marking tickets prohibited; exceptions.

Marking of tickets in any way is prohibited except by a player to claim a prize or by the department or a retailer to identify or to void the ticket.

§ 3.16. Penalty for counterfeit or altered ticket.

Forging, altering or fraudulently making any lottery ticket or knowingly presenting a forged, counterfeit or altered ticket for prize payment or transferring such a ticket to another person to be presented for prize payment is a Class 6 felony in accordance with the state lottery law.

§ 3.17. Lost, stolen, destroyed tickets.

The department is not liable for lost, stolen or destroyed tickets.

The director may honor a prize claim of an apparent winner who does not possess the original ticket if the claimant is in possession of information which demonstrates that the original ticket meets the following criteria and can be validated through other means. The exception does not apply to an instant game ticket the prize for which is a free ticket or is $25 or less.

1. The claim form and a photocopy of the ticket, or photocopy of the original claim form and ticket, are timely filed with the department;

2. The prize for which the claim is filed is an unclaimed winning prize as verified in the department's records;

3. The prize has not been claimed within the required redemption period; and

4. The claim is filed within 180 days of the drawing or within the redemption period, as established by game rules.

§ 3.18. Erroneous or mutilated ticket.

The department is not liable for erroneous or mutilated tickets. The director, at his option, may replace an erroneous or mutilated ticket with an unplayed ticket for the same or a later instant game.

§ 3.19. Retailer to pay low-tier prizes.

Low-tier prizes (those of $25 or less in cash or free instant game tickets) shall be paid by the retailer who sold the winning ticket, or by the department at the option of the ticket holder, or by the department when the ticket cannot be validated by the retailer.

§ 3.20. Retailers' prize payment procedures.

Procedures for prize payments by retailers are as follows:

1. Retailers may pay cash prizes in cash, by certified check, cashier's check, business check, or money order, or by any combination of these methods.

2. If payment of a prize by a check presented to a claimant by a retailer is denied for any reason, the retailer is subject to the same service charge interest and penalty payments that would apply if the check were made payable to the department. A claimant whose prize check is denied shall notify the department to obtain the prize.

3. Retailers shall pay claims for low-tier prizes during all normal business hours.

4. Prize claims shall be paid only at the location specified on the license.

5. The department will reimburse a retailer for prizes of between $26 and $599 paid up to 180 days after an instant game ends.

§ 3.21. Retailer to validate winning ticket.

Before paying a prize claim, the retailer ~~shall~~ *should* validate the winning ticket. The retailer ~~shall~~ *should* follow validation procedures listed in these regulations or obtained from the department. *Retailers who pay claims without validating the ticket do so at their own financial risk.*

§ 3.22. When retailer cannot validate ticket.

If, for any reason, a retailer is unable to validate a prize-winning ticket, the retailer shall provide the ticket holder with a department claim form and instruct the ticket holder on how to file a claim with the department.

§ 3.23. No reimbursement for retailer errors.

The department shall not reimburse retailers for prize claims paid in error.

§ 3.24. Retailer to void winning ticket.

After a winning ticket is validated and signed by the ticket holder, the retailer shall physically void the ticket to prevent it from being redeemed more than once. The manner of voiding the ticket will be prescribed by the director.

§ 3.25. Prizes of less than $600.

A retailer may elect to pay instant prizes between $26 and $599 won on tickets validated and determined by the department to be official prize winners, regardless of where the tickets were sold. If the retailer elects to pay prizes of up to $599, the following terms and conditions apply:

1. The retailer shall execute an agreement with the department to pay higher prize limits.

2. The retailer shall pay all prizes agreed to up to $599 ~~or less~~ on validated tickets presented to that retailer.

3. The retailer shall display special informational material provided by or approved by the department informing the public of the exceptional prize payments available from that retailer.

4. Nothing in this section shall be construed to prevent the department from accepting an agreement from a retailer to pay prize amounts $26 *or* more but less than $599.

§ 3.26. Additional validation requirements.

Before paying any prize between $26 and $599, the retailer ~~shall~~ *should* :

1. Reserved

2. Inspect the ticket to assure that it conforms to each validation criterion listed in these regulations and to any additional criteria the director may specify;

3. Report to the department the ticket number, validation code and validation number of the ticket; and

4. Obtain an authorization number for prize payment from the department.

§ 3.27. When prize shall be claimed from the department.

The department will pay prizes in any of the following circumstances:

1. If a retailer cannot validate a claim which the retailer otherwise would pay, the ticket holder shall ~~send or~~ present ~~to the department~~ a completed claim form and the signed ticket *at any department regional office or mail both the completed claim form and the signed ticket to the department central office.*

2. If a ticket holder is unable to return to the retailer from which the ticket was purchased *to claim a prize which the retailer otherwise would pay* , ~~a completed claim form and~~ *the ticket holder may present* the signed ticket ~~may be presented~~ *at any department regional office* or ~~mailed~~ *mail both a completed claim form and the signed ticket* to the department *central office* .

3. If the prize amount is over the limit paid by the retailer from which the ticket was purchased, *the ticket holder may present* a completed claim form *, if required,* and the signed ticket ~~shall be presented~~ *to any department regional office* or ~~mailed~~ *mail both a completed claim form and the signed ticket* to the department *central office* .

§ 3.28. Prizes of $25,000 or less.

Prizes of $25,000 or less may be claimed from any of the department's regional offices. Regional offices will pay prizes by check after tickets are validated and after any other applicable requirements contained in these regulations are met.

§ 3.29. Prizes of more than $25,000.

Prizes of more than $25,000 and noncash prizes other than free lottery tickets may be claimed from the department's central office in Richmond. The central office will pay *cash* prizes by check, after tickets are validated and after any other applicable requirements contained in these regulations are met.

§ 3.30. When claims form required.

A claims form for a winning ticket may be obtained from any department office or any lottery sales retailer.

A. Claims forms shall be required to claim any prize from the department's central office.

B. Claims forms shall be required to claim any prize of $600 or more from the department's regional offices.

C. Reserved.

D. The director may, at his discretion, require claims forms to be filed to claim prizes.

§ 3.31. Department action on claims for prizes submitted to department.

The department shall validate the winning ticket claim according to procedures contained in these regulations.

A. If the claim is not valid, the department will notify the ticket holder promptly.

B. If the claim is mailed to the department and the department validates the claim, a check for the prize amount will be mailed to the winner.

C. If an individual presents a claim to the department in person and the department validates the claim, a check for the prize amount will be presented to the bearer.

§ 3.32. Withholding, notification of prize payments.

A. When paying any prize of $600 or more, the department shall: Department of Taxation and the federal Internal Revenue Service; and

2. Withhold any moneys due for delinquent debts listed with the Department of Taxation's set-off debt collection program.

B. When paying any prize of more than $5,000, the department shall provide for the withholding of the applicable amount of state and federal income tax of persons claiming a prize for the winning ticket.

§ 3.33. Grand prize event.

If an instant game includes a grand prize or jackpot event, the following general criteria shall be used:

1. Entrants in the event shall be selected from tickets which meet the criteria stated in specific game rules set by the director.

2. Participation in the drawing(s) shall be limited to those tickets which are actually received and validated by the department on or before the date announced by the director.

3. If, after the event is held, the director determines that a ticket should have been entered into the event, the director may place that ticket into a grand prize drawing for the next equivalent instant game. That action is the extent of the department's liability.

4. The director shall determine the date(s), time(s)

and procedures for selecting grand prize winner(s) for each instant game. The proceedings for selection of the winners shall be open to members of the news media and to either the general public or entrants or both.

§ 3.34. Director may postpone drawing.

The director may postpone any drawing to a certain time and publicize the postponement if he finds that the postponement will serve and protect the public interest.

§ 3.35. Valid ticket described.

To be valid, a Virginia lottery game ticket shall meet all of the validation requirements listed here:

1. The ticket shall have been issued by the department in an authorized manner.

2. The ticket shall not be altered, unreadable, reconstructed, or tampered with in any way.

3. The ticket shall not be counterfeit in whole or in part.

4. The ticket shall not have been stolen or appear on any list of void or omitted tickets on file with the department.

5. The ticket shall be complete and not blank or partly blank, miscut, misregistered, defective, or printed or produced in error.

6. The ticket shall have exactly one play symbol and exactly one caption under each of the rub-off spots, exactly one ticket number, exactly one validation code, and exactly one validation number. These items shall be present in their entirety, legible, right side up, and not reversed in any manner.

7. The validation number of an apparent winning ticket shall appear on the department's official list of validation numbers of winning tickets provided by the vendor of the instant tickets. A ticket with that validation number shall not have previously been paid.

8. The ticket shall pass all additional confidential validation requirements set by the department.

§ 3.36. Invalid ticket.

An instant ticket which does not pass all the validation requirements listed in these regulations and any validation requirements contained in the rules for its instant game is invalid. An invalid ticket is not eligible for any prize.

§ 3.37. Replacement of ticket.

The director may replace an invalid ticket with an unplayed ticket from the same or another instant game. If a defective ticket is purchased, the department's only liability or responsibility shall be to replace the defective ticket with an unplayed ticket from the same or another instant game or to refund the purchase price, at the department's option.

§ 3.38. When ticket is partially mutilated or not intact.

If an instant ticket is partially mutilated or if the ticket is not intact but can still be validated by other validation tests, the director may pay the prize for that ticket.

§ 3.39. Director's decision final.

All decisions of the director regarding ticket validation shall be final.

§ 3.40. When prize payable over time.

Unless the rules for any specific instant game provide otherwise, any cash prize of ~~$500,000~~ *$100,001* or more will be paid in multiple payments over time. The schedule of payments shall be designed to pay the winner equal dollar amounts ~~each year~~ *in each year, with the exception of the first,* until the total payments equal the prize amount.

§ 3.41. Rounding total prize payment.

When a prize or share is to be paid over time, except for the first payment, the director may round the actual amount of the prize or share to the nearest $1,000 to facilitate purchase of an appropriate funding mechanism.

§ 3.42. When prize payable for "life."

If a prize is advertised as payable for the life of the winner, only an individual may claim the prize. If a claim is filed on behalf of a group, company, corporation or any other type of organization, the life of the claim shall be 20 years.

* * * *

NOTICE: The forms used in administering the Instant Game Regulations are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the State Lottery Department, 2201 West Broad Street, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Retailer License Application
Personal Data Form
Retailer Location Form
Retailer Data Collection
Authorization Agreement for Preauthorizated Payments (A-1)
Virginia Lottery Licensed Retailer Certificate (4/90)
Bond Continuation Certificate (letter)

Commonwealth of Virginia Lottery Bond Application
Special Notice on Bonding for Lottery Retailers
Winner Claim Form (SLD-0007, 3/89)
Winner-Gram (SLD0016)
We're Sorry But . . . (SLD0015)
Returned Ticket Receipt - Full Pack Returns
Returned Ticket Receipt - Partial Pack Returns
Ticket Dispenser Agreement (SLD-0129, 3/89)
Agreement to Pay Mid-Tier Prizes
Invoice
Statement
Retailer Guidelines for Using Advertising Approval Form
Retailer Advertising Approval Form
Stolen Ticket Report (766.000, 1/89)

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Title of Regulation: **VR 447-02-2. On-Line Game Regulations.**

Statutory Authority: § 58.1-4007 of the Code of Virginia.

Effective Date: April 24, 1991.

Summary:

The State Lottery Department is amending sections of the On-Line Game Regulations which established procedures specificaly related to on-line lottery games, including standards and requirements for licensing retailers, specific operational parameters for the conduct of the game, on-line ticket validation requirements and payment of prizes.

The regulations amend several major portions of the On-Line Game Regulations: (i) adds a new feature, lottery ticket sales by subscription, to on-line games to allow the player to purchase tickets through the mail for a specified time period; (ii) waives service charges, interest and penalties if a late payment by a lottery retailer is caused by a bank or by the department; (iii) changes the term of licensure from annual to perpetual, subject to an annual review of retailer eligibility and the payment of an annual fee, approved earlier as an emergency regulation; (iv) reduces the prize redemption period for free on-line tickets from 180 to 60 days; (v) expands standards for licensing to include a requirement that the retailer have the ability to offer high point of sale material, a favorable image, the ability to pay prizes during maximum selling hours, and a commitment to authorize employees to participate in lottery training; and (vi) authorizes acceptance of a photocopy of the ticket for prize payment under certain circumstances.

Subsequent to publication of the regulations in proposed form, a revision was made to § 1.8 regarding licensed retailers' compensation. Current regulations require inclusion of any approved lottery retailer incentive or bonus program in the rules to the specific lottery game to which it applies. Frequently, the incentive programs apply to more than one lottery game and, occasionally, to lottery games previously adopted and being sold. Therefore, rules from each of the prior games would have to be revised. Because the purpose of including the programs in the rules is for public notice, the same result can be achieved by issuing a Director's Order which is similarly published.

VR 447-02-2. On-Line Game Regulations.

PART I.
ON-LINE GAMES.

§ 1.1. Development of on-line games.

The director shall select, operate, and contract for the operation of on-line games which meet the general criteria set forth in these regulations. The board shall determine the specific details of each on-line lottery game after consultation with the director. These details include, but are not limited to:

1. The type or types of on-line lottery games;

2. Individual prize amounts and overall prize structure;

3. Types of noncash prizes, if any;

4. The amount and type of any jackpot or grand prize which may be awarded and how awarded; and

5. Chances of winning.

§ 1.2. General definitions for on-line games.

" ~~Auto-picks~~ *Auto pick*" means ~~computer generated numbers or items. The director may select a different name to identify this feature for marketing purposes.~~ *the same as "easy pick."*

"Breakage" means the fraction of a dollar not paid out due to rounding down and shall be used exclusively to fund prizes.

"Cancelled ticket" means a ticket that *(i)* has been placed into the terminal, whereupon the terminal must read the information from the ticket *; and* cancel the transaction ~~and brand the ticket with a mark or words indicating that the ticket is cancelled and void~~ *or (ii) whose validation number has been manually entered into the terminal via the keyboard and cancelled .*

"Certified drawing" means a drawing in which a lottery official and an independent certified public accountant attest that the drawing equipment functioned properly and that a random selection of a winning combination has occurred.

"Drawing" means a procedure by which the lottery

randomly selects numbers or items in accordance with the specific game rules for those games requiring random selection of number(s) or item(s).

"Duplicate ticket" means a ticket produced by any means other than by an on-line terminal with intent to imitate the original ticket.

"Easy pick" means computer generated numbers or items.

"On-line game" means a lottery game, the play of which is dependent upon the use of an on-line terminal in direct communication with an on-line game main frame operated by or at the direction of the department.

"On-line lottery retailer" means a licensed lottery retailer who has entered an agreement with the department to sell on-line tickets.

"On-line system" means the department's on-line computer system consisting of on-line terminals, central processing equipment, and a communication network.

"On-line terminal" means computer hardware through which a combination of numbers or items is selected or generated and through which on-line tickets are generated and claims may be validated.

"On-line ticket" means a computer-generated ticket issued by an on-line lottery retailer to a player as a receipt for the number, numbers, or items or combination of ~~number~~ *numbers* or items the player has selected.

"Play" means a wager on a single set of selected numbers.

"Player-selected item" means a number or item or group of numbers or items selected by a player in connection with an on-line game. Player-selected items include selections of items randomly generated by the computer on-line system. Such computer-generated numbers or items are also known as " ~~auto-picks~~ *auto picks," "easy picks*" or "quick picks."

"Quick pick" means the same as " ~~auto~~ *easy* pick."

"Retailer," as used in these on-line game regulations, means a licensed on-line lottery retailer, unless the context clearly requires otherwise.

"Roll stock" means the paper roll placed into the lottery retailer terminals from which a unique lottery ticket is generated by the computer, displaying the player selected item(s) or number(s).

"Share" means a percentage of ownership in a winning ticket.

"Subscription game" means a lottery game in which the player can purchase on-line game tickets through the mail, for a specific period of time, and for which the player is automatically entered in each on-line drawing during the period for which the subscription is purchased.

"Subscription ticket" means an on-line ticket which provides the ability to play a specific number of games utilizing the same numbers, selected by the player, for a period of consecutive weeks as specified on the ticket.

"Validation" means the process of determining whether an on-line ticket presented for payment is a winning ticket.

"Validation number" means a unique number assigned by the on-line central computer and printed on the front of each on-line ticket which is used for validation.

"Winning combination" means two or more items or numbers selected by a drawing.

§ 1.3. Prize structure.

The prize structure for any on-line game shall be designed to return to winners approximately 50% of gross sales.

A. The specific prize structure for each type of on-line game shall be determined in advance by the board.

B. From time to time, the board may determine temporary adjustments to the prize structure to account for breakage or other fluctuations in the anticipated redemption of prizes.

§ 1.4. Drawing and selling times.

A. Drawings shall be conducted at times and places designated by the director and publicly announced by the department.

B. On-line tickets may be purchased up to a time prior to the drawing as specified in the on-line drawing rules. That time will be designated by the director.

§ 1.5. Ticket price.

A. The sale price of a lottery ticket for each game will be determined by the board ~~and will be between $.50 and $15~~ . These limits shall not operate to prevent the sale of more than one lottery play on a single ticket. *Unless authorized by the board,* lottery retailers may not discount the sale price of on-line game tickets or provide free lottery tickets as a promotion with the sale of on-line tickets. This section shall not prevent a licensed retailer from providing free on-line tickets with the purchase of other goods or services customarily offered for sale at the retailer's place of business; provided, however, that such promotion shall not be for the primary purpose of inducing persons to participate in the lottery. (see § 1.9)

B. This section shall not apply to the redemption of a

winning on-line game ticket the prize for which is another free ticket.

§ 1.6. Ticket cancellation.

A ticket may be cancelled and a refund of the purchase price obtained at the request of the bearer of the ticket under the following conditions:

1. To be accepted for cancellation, the ticket must be presented to the lottery retailer location at which the ticket was sold, prior to the time of the drawing and within the same business day it was purchased.

2. Cancellation may only be effected by the following two procedures:

a. Inserting the ticket into the lottery terminal, whereupon the terminal must read the information from the ticket and cancel the transaction.

b. After first determining that the preceding procedure cannot be utilized successfully to cancel the ticket, the terminal operator may cancel the ticket by manually entering the ticket validation number into the terminal via the keyboard.

Any ticket which cannot be cancelled by either of these procedures remains valid for the drawing for which purchased. Any ticket which is mutilated, damaged or has been rendered unreadable, and cannot be inserted into or read by the lottery terminal or whose validation number cannot be read and keyed into the terminal, cannot be cancelled by any other means.

3. The cancelled ticket must be surrendered by the bearer to the retailer.

4. On a case-by-case basis, credit may be provided to retailers for tickets which could not be cancelled by either of the two methods described in § 1.6 2. Such credit may be given provided unusual, verifiable circumstances are present which show that the department's computer system could not accept the cancellation within the same day the ticket was purchased or that the ticket was produced by an unusual retailer error. The retailer must notify the department's Hotline prior to the time of the drawing and within the same business day the ticket was purchased.

5. The director may approve credit for other cancellation requests not described in this section.

6. The lottery's internal auditor will audit cancelled tickets on a sample basis.

§ 1.7. Chances of winning.

The director shall publicize the overall chances of winning a prize in each on-line game. The chances may be printed in informational materials.

§ 1.8. Licensed retailers' compensation.

A. Licensed retailers shall receive 5.0% compensation on all net sales from on-line games. "Net sales" are gross sales less cancels.

B. The board shall approve any bonus or incentive system for payment to retailers. The director will publicize any such system [~~in the rules of the game(s) to which it applies~~ *by administrative order*]. The director may then award such cash bonuses or other incentives to retailers.

§ 1.9. Retailers' conduct.

A. Retailers shall sell on-line tickets at the price fixed by the board, unless the board allows reduced prices or ticket give-aways.

B. All ticket sales shall be for cash, check, cashier's check, traveler's check or money order at the discretion of and in accordance with the licensed retailer's policy for accepting payment by such means. A ticket shall not be purchased with credit cards, food stamps or food coupons.

C. All ticket sales shall be final. Retailers shall not accept ticket returns except as allowed by department regulations or policies, or with the department's specific approval.

D. Tickets shall be sold during all normal business hours of the lottery retailer when the on-line terminal is available unless the director approves otherwise.

E. Tickets shall be sold only at the location listed on each retailer's license from the department.

F. On-line retailers must offer for sale all lottery products offered by the department.

G. An on-line game ticket shall not be sold to, purchased by, ~~or~~ given as a gift to *or redeemed from* any individual under 18 years of age.

H. On-line retailers shall furnish players with proper claim forms provided by the department.

I. On-line retailers shall post winning numbers prominently.

J. On-line retailers and employees who will operate on-line equipment shall attend training provided by the department and allow only trained personnel to operate terminals.

K. Unsupervised retailer employees who sell or otherwise vend lottery tickets must be at least 18 years of age. Employees not yet 18 but at least 16 years of age may sell or vend lottery tickets so long as they are

supervised by ~~a person 18 years of age or older~~ *the manager or supervisor in charge at the location where the tickets are being sold* .

§ 1.10. End of game; suspension.

The director may suspend or terminate an on-line game without advance notice if he finds that this action will serve and protect the public interest.

PART II.
LICENSING OF RETAILERS FOR ON-LINE GAMES.

§ 2.1. Licensing.

A. Generally.

The director may license persons as lottery retailers for on-line games who will best serve the public convenience and promote the sale of tickets and who meet the eligibility criteria and standards for licensing.

B. For purposes of this part on licensing, "person" means an individual, association, partnership, corporation, club, trust, estate, society, company, joint stock company, receiver, trustee, assignee, referee, or any other person acting in a fiduciary or representative capacity, whether appointed by a court or otherwise, and any combination of individuals. "Person" also means all departments, commissions, agencies and instrumentalities of the Commonwealth, including its counties, cities, and towns.

§ 2.2. Eligibility.

A. Eighteen years of age and bondable.

Any person who is 18 years of age or older and who is bondable may be considered for licensure, except no person may be considered for licensure:

1. Who will be engaged ~~solely~~ *primarily* in the business of selling lottery tickets; or

2. Who is a board member, officer or employee of the State Lottery Department or who resides in the same household as board member, officer or employee of the department; or

3. Who is a vendor to the department of instant or on-line lottery tickets or goods or data processing services, whose tickets, goods or services are provided directly to the lottery department, or whose business is owned by, controlled by, or affiliated with a vendor of instant or on-line lottery tickets or goods or data processing services whose tickets, goods or services are provided directly to the lottery department.

B. Form submission.

The submission of forms or data for licensure does not in any way entitle any person to receive a license to act as an on-line lottery retailer.

§ 2.3. General standards for licensing.

A. Selection factors for licensing.

The director may license those persons who, in his opinion, will best serve the public interest and public trust in the lottery and promote the sale of lottery tickets. The director will consider the following factors before issuing or renewing a license:

1. The financial responsibility and integrity of the retailer, to include:

a. A credit and criminal record history search or when deemed necessary a full investigation of the retailer;

b. A check for outstanding delinquent state tax liability;

c. A check for required business licenses, tax and business permits; and

d. An evaluation of physical security at the place of business, including insurance coverage.

2. The accessibility of his place of business to public, to include:

a. The hours of operation compared to the on-line system selling hours;

b. The availability of parking including ease of ingress and egress to parking;

c. Public transportation stops and passenger traffic volume;

d. The vehicle traffic density, including levels of congestion in the market area;

e. Customer transaction count within the place of business;

f. Other factors indicating high public accessibility and public convenience when compared with other retailers; and

g. Adequate space and physical layout to sell a high volume of lottery tickets efficiently.

3. The sufficiency of existing lottery retailers to serve the public convenience, to include:

a. The number of and proximity to other lottery retailers in the market area;

b. The expected impact on sales volume of potentially competing lottery retailers;

c. The adequacy of coverage of all regions of the Commonwealth with lottery retailers; and

d. The population to terminal ratio, compared to other geographical market areas.

4. The volume of expected lottery ticket sales, to include:

a. Type and volume of the products and services sold by the retailer;

b. Dollar sales volume of the business;

c. Sales history of the market area;

d. Sales history for instant tickets, if already licensed as an instant retailer;

e. Volume of customer traffic in place of business; and

f. Market area potential, compared to other market areas.

5. The ability to offer high levels of customer service to on-line lottery players, including:

a. A history demonstrating successful use of lottery product related promotions;

b. Volume and quality of point of sale display;

c. A history of compliance with lottery directives;

d. Ability to display jackpot prize amounts to pedestrians and vehicles passing by;

e. A favorable image consistent with lottery standards;

f. Ability to pay prizes less than $600 during maximum selling hours, compared to other area retailers;

g. Commitment to authorize employee participation in all required on-line lottery training; and

h. Commitment and opportunity to post jackpot levels near the point of sale.

B. Additional factors for selection.

The director may develop and, by director's order, publish additional criteria which, in the director's judgment, are necessary to serve the public interest and public trust in the lottery.

C. Filing of forms with the department.

After notification of selection as an on-line lottery retailer, the retailer shall file required forms with the department. The retailer must submit all information required to be considered for licensing. Failure to submit required forms and information within the times specified in these regulations may result in the loss of the opportunity to become or remain a licensed on-line retailer. The forms to be submitted shall include:

1. Signed retailer agreement;

2. Signed EFT Authorization form with a voided check or deposit slip from the specified account; and

3. Executed bond requirement.

§ 2.4. Bonding of lottery retailers.

A. Approved retailer to secure bond.

A lottery retailer approved for licensing shall obtain a surety bond in the amount of $10,000 from a surety company entitled to do business in Virginia. If the retailer is already bonded for instant games, a second bond will not be required. However, the amount of the original bond must be increased to $10,000. The purpose of the surety bond is to protect the Commonwealth from a potential loss in the event the retailer fails to perform his responsibilities.

1. Unless otherwise provided under subsection C of this section, the surety bond shall be in the amount and penalty of $10,000 and shall be payable to the State Lottery Department and conditioned upon the faithful performance of the lottery retailer's duties.

2. Within 15 calendar days of receipt of the "On-Line License Approval Notice," the lottery retailer shall return the properly executed "Bonding Requirement" portion of the "On-Line License Approval Notice" to the State Lottery Department to be filed with his record.

B. Continuation of surety bond on ~~renewal of~~ *annual* license *review* .

A lottery retailer ~~applying for renewal of a license~~ *whose license is being reviewed* shall:

1. Obtain a letter or certificate from the surety company to verify that the surety bond is being continued for the *annual* license ~~renewal~~ *review* period; and

2. Submit the surety company's letter or certificate with the required *annual* license ~~renewal~~ *review* fee to the State Lottery Department.

C. Sliding scale for surety bond amounts.

The department may establish a sliding scale for surety bonding requirements based on the average volume of

lottery ticket sales by a retailer to ensure that the Commonwealth's interest in tickets to be sold by a licensed lottery retailer is adequately safeguarded. Such sliding scale may require a surety bond amount either greater or lesser than the amount fixed by subsection A of this section.

D. Effective date for sliding scale.

The sliding scale for surety bonding requirements will become effective when the director determines that sufficient data on lottery retailer ticket sales volume activity are available. Any changes in a retailer's surety bonding requirements that result from instituting the sliding scale will become effective only at the time of the retailer's next renewal action.

§ 2.5. Lottery bank accounts and EFT authorization.

A. Approved retailer to establish lottery bank account.

A lottery retailer approved for licensing shall establish a separate bank account to be used exclusively for lottery business in a bank participating in the automatic clearing house (ACH) system. A single bank account may be used for both on-line and instant lottery business.

B. Retailer's use of lottery account.

The lottery account will be used by the retailer to make funds available to permit withdrawals and deposits initiated by the department through the electronic funds transfer (EFT) process to settle a retailer's account for funds owed by or due to the retailer from the sale of tickets and the payment of prizes. All retailers shall make payments to the department through the electronic funds transfer (EFT) process unless the director designates another form of payment and settlement under terms and conditions he deems appropriate.

C. Retailer responsible for bank charges.

The retailer shall be responsible for payment of any fees or service charges assessed by the bank for maintaining the required account.

D. Retailer to authorize electronic funds transfer.

Within 15 calendar days of receipt of the "On-Line License Approval Notice," the lottery retailer shall return the properly executed "On-Line Electronic Funds Transfer Authorization" portion of the "License Approval Notice" to the department recording the establishment of his account.

E. Change in retailer's bank account.

If a retailer finds it necessary to change his bank account from one bank account to another, he must submit a newly executed "Electronic Funds Transfer Authorization" form for the new bank account. The retailer may not discontinue use of his previously approved bank account until he receives notice from the department that the new account is approved for use.

F. Director to establish EFT account settlement schedule.

The director will establish a schedule for processing the EFT transactions against retailers' lottery bank accounts and issue instructions to retailers on how settlement of accounts will be made.

§ 2.6. Deposit of lottery receipts; interest and penalty for late payment; dishonored EFT transfers or checks.

A. Payment due date.

Payments shall be due as specified by the director in the instructions to retailers regarding the settlement of accounts.

B. Penalty and interest charge for late payment.

Any retailer who fails to make payment when payment is due will have his on-line terminal ~~disconnected~~ *inactivated* . The retailer will not be ~~reconnected~~ *reactivated* until payment is made by cashiers check, certified check or wire transfer. Additionally, interest will be charged on the moneys due plus a $25 penalty. The interest charge will be equal to the "Underpayment Rate" established pursuant to § 6621(a)(2) of the Internal Revenue Code of 1954, as amended. The interest charge will be calculated beginning the date following the retailer's due date for payment through the day preceding receipt of the late payment by the department for deposit.

C. Service charge for dishonored EFT transfer or bad check.

In addition to the penalty authorized by subsection B of this section, the director will assess a service charge of $25 against any retailer whose payment through electronic funds transfer (EFT) or by check is dishonored.

D. Service charge for debts referred for collection.

If the department refers a debt of any retailer to the Attorney General, the Department of Taxation or any other central collection unit of the Commonwealth, the retailer owing the debt shall be liable for an additional service charge which shall be in the amount of the administrative costs associated with the collection of the debt incurred by the department and the agencies to which the debt is referred.

E. Service charge, interest and penalty waived.

The service charge, interest and penalty charges may be waived when the event which would otherwise cause a service charge, interest or penalty to be assessed is not in any way the fault of the lottery retailer. For example, a waiver may be granted in the event of a bank error or

lottery error.

§ 2.7. License term and ~~renewal~~ *annual review* .

A. License term.

A general on-line license for an approved lottery retailer shall be issued ~~for a one-year period~~ *on a perpetual basis subject to an annual determination of continued retailer eligibility and the payment of an annual fee fixed by the board* . A general on-line license requires the retailer to sell both on-line and instant lottery tickets.

B. ~~License renewal~~ *Annual license review* .

~~A general on-line license shall be renewed annually at least 30 days prior to its expiration date and shall be accompanied by the appropriate fee(s) as specified elsewhere in these regulations.~~ *The annual fee shall be collected within the 30 days preceding a retailer's anniversary date. Upon receipt of the annual fee, the general license shall be continued so long as all eligibility requirements are met* . The director may implement a staggered, monthly basis for annual license ~~renewals~~ *reviews* and allow for the proration of annual license fees ~~to credit licensees for the time remaining on their current license when the staggered renewal requirement is imposed~~ . This section shall not be deemed to allow for a refund of license fees when a license is terminated, revoked or suspended for any other reason.

C. Amended license term.

~~An amended license shall be valid for the remainder of the period of the license it replaces.~~ *The annual fee for an amended license will be due on the same date as the fee for the license it replaced.*

D. Special license.

The director may issue special licenses. Special licenses shall be for a limited duration and under terms and conditions that he determines appropriate to serve the public interest.

E. Surrender of license certificate.

If the license of a lottery retailer is suspended, revoked or not continued from year to year, the lottery retailer shall surrender the license certificate upon demand.

§ 2.8. License fees.

A. License fee.

The fee for a lottery retailer general license to sell on-line game tickets shall be $25. *Payment of this fee shall entitle the retailer to sell both on-line and instant game tickets.* The general license fee to sell on-line game tickets shall be paid for each location to be licensed. This fee is nonrefundable.

B. *Annual* license ~~renewal~~ fee.

The annual fee for ~~renewal of~~ a lottery retailer general license to sell on-line game tickets shall be an amount determined by the board at its November meeting or as soon thereafter as practicable for all ~~renewals~~ *reviews* occurring in the next calendar year. The ~~renewal~~ fee shall be designed to recover all or a portion of the annual costs of the department in providing services to the retailer. The ~~renewal~~ fee shall be paid for each location for which a license is ~~renewed~~ *reviewed* . This fee is nonrefundable. The ~~renewal~~ fee shall be submitted ~~at least~~ *within the* 30 days ~~prior to the expiration of~~ *preceding* a retailer's ~~general license~~ *anniversary date* .

C. Amended license fee.

The fee for processing an amended license for a lottery retailer general license shall be an amount as determined by the board at its November meeting or as soon thereafter as practicable for all amendments occurring in the next calendar year. The amended license fee shall be paid for each location affected. This fee is nonrefundable. An amended license shall be submitted in cases where a business change has occurred.

§ 2.9. Fees for operational costs.

A. Installation fee.

The fee for initial terminal telecommunications installation for the on-line terminal shall be $275. This fee may be subject to change based upon an annual cost review by the department.

1. If the retailer has purchased a business where a terminal is presently installed or telecommunication service is available, a fee of $25 per year shall be charged upon issuance of a new license.

2. No installation fee will be charged if interruption of service to the terminal has not occurred.

B. Weekly on-line telecommunications line charge.

Each retailer shall be assessed a weekly charge of $15 per week. This fee may be subject to change based upon an annual cost review by the department.

§ 2.10. Transfer of license prohibited; invalidation of license.

A. License not transferrable.

A license issued by the director authorizes a specified person to act as a lottery retailer at a specified location as set out in the license. The license is not transferrable to any other person or location.

B. License invalidated.

A license shall become invalid in the event of any of the following circumstances:

1. Change in business location;

2. Change in business structure (e.g., from a partnership to a sole proprietorship);

3. Change in the business owners listed on the original personal data forms for which submission of a personal data form is required under the license procedure.

C. Amended personal data form required.

A licensed lottery retailer who anticipates any change listed in subsection B must notify the department of the anticipated change at least 30 calendar days before it takes place and submit an amended personal data form. The director shall review the changed factors in the same manner that would be required for a review of an original personal data form.

§ 2.11. Denial, suspension, revocation or ~~nonrenewal~~ *noncontinuation* of license.

A. Grounds for refusal to license.

The director may refuse to issue a license to a person if the person ~~has been~~ *does not meet the eligibility criteria and standards for licensing as set out in these regulations or if* :

1. *The person has been* convicted of a felony;

2. *The person has been* convicted of a crime involving moral turpitude;

3. *The person has been* convicted of any fraud or misrepresentation in any connection;

4. *The person has been* convicted of bookmaking or other forms of illegal gambling;

5. *The person as been* convicted of knowingly and willfully falsifying, or misrepresenting, or concealing a material fact or makes a false, fictitious, or fraudulent statement or misrepresentation;

6. ~~Determined not to meet the eligibility criteria or general standards for licensing~~ *The person's place of business caters to or is frequented predominantly by persons under 18 years of age;*

7. The nature of the person's business constitutes a threat to the health or safety of prospective lottery patrons;

8. The nature of the person's business is not consonant with the probity of the Commonwealth; or

9. The person has committed any act of fraud, deceit, misrepresentation, or conduct prejudicial to public confidence in the state lottery.

B. Grounds for refusal to license partnership or corporation.

In addition to refusing a license to a partnership or corporation under subsection A of this section, the director may also refuse to issue a license to any partnership or corporation if he finds that any general or limited partner or officer or director of the partnership or corporation has been convicted of any of the offenses cited in subsection A of this section.

C. Appeals of refusal to license.

Any person refused a license under subsection A or B may appeal the director's decision in the manner provided by VR 447-01-02, Part III, Article 2, § 3.4.

D. Grounds for suspension, revocation or refusal to ~~renew~~ *continue* license.

~~After notice and a hearing,~~ The director may suspend, revoke, or refuse to ~~renew~~ *continue* a license for any of the following reasons:

1. Failure to properly account for on-line terminal ticket roll stock, for cancelled ticket, for prizes claimed and paid, or for the proceeds of the sale of lottery tickets;

2. Failure to file or maintain the required bond or the required lottery bank account;

3. Failure to comply with applicable laws, instructions, terms or conditions of the license, or rules and regulations of the department concerning the licensed activity, especially with regard to the prompt payment of claims;

4. Conviction, following the approval of the license, of any of the offenses cited in subsection A;

5. Failure to file any return or report or to keep records or to pay any fees or other charges as required by the state lottery law or the rules or regulations of the department or board;

6. Commission of any act of fraud, deceit, misrepresentation, or conduct prejudicial to public confidence in the state lottery;

7. Failure to maintain lottery ticket sales at a level sufficient to meet the department's administrative costs for servicing the retailer, provided that the public convenience is adequately served by other retailers. This failure may be determined by comparison of the retailer's sales to a sales quota established by the director;

8. Failure to notify the department of a material change, after the license is issued, of any matter required to be considered by the director in the licensing process;

9. Failure to comply with lottery game rules; ~~and~~

10. Failure to meet minimum point of sale standards ~~.~~ ;

11. The person's place of business caters to or is frequented predominantly by persons under 18 years of age;

12. The nature of the person's business constitutes a threat to the health or safety of prospective lottery patrons; or

13. The nature of the person's business is not consonant with the probity of the Commonwealth.

E. Notice of intent to suspend, revoke or deny ~~renewal~~ *continuation* of license.

Before taking action under subsection C, the director will notify the retailer in writing of his intent to suspend, revoke or deny ~~renewal~~ *continuation* of the license. The notification will include the reason or reasons for the proposed action and will provide the retailer with the procedures for requesting a hearing before the board. Such notice shall be given to the retailer at least 14 calendar days prior to the effective date of suspension, revocation or denial.

F. Temporary suspension without notice.

If the director deems it necessary in order to serve the public interest and maintain public trust in the lottery, he may temporarily suspend a license without first notifying the retailer. Such suspension will be in effect until any prosecution, hearing or investigation into possible violations is concluded.

G. Surrender of license and lottery property upon revocation or suspension.

A retailer shall surrender his license to the director by the date specified in the notice of revocation or suspension. The retailer shall also surrender the lottery property in his possession and give a final accounting of his lottery activities by the date specified by the director.

§ 2.12. Responsibility of lottery retailers.

Each retailer shall comply with all applicable state and federal laws, rules and regulations of the department, license terms and conditions, specific rules for all applicable lottery games, and directives and instructions which may be issued by the director.

§ 2.13. Display of license.

License displayed in general view. Every licensed lottery retailer shall conspicuously display his lottery license in an area visible to the general public where lottery tickets are sold.

§ 2.14. Display of material.

A. Material in general view.

Lottery retailers shall display lottery point-of-sale material provided by the director in a manner which is readily seen by and available to the public.

B. Prior approval for retailer-sponsored material.

A lottery retailer may use or display his own promotional and point-of-sale material, provided it has been submitted to and approved for use by the department in accordance with instructions issued by the director.

C. Removal of unapproved material.

The director may require removal of any licensed retailer's lottery promotional material that has not been approved for use by the department.

§ 2.15. Inspection of premises.

Access to premises by department. Each lottery retailer shall provide access during normal business hours or at such other times as may be required by the director or state lottery representatives to enter the premises of the licensed retailer. The premises include the licensed location where lottery tickets are sold or any other location under the control of the licensed retailer where the director may have good cause to believe lottery materials or tickets are stored or kept in order to inspect the lottery materials or tickets and the licensed premises.

§ 2.16. Examination of records; seizure of records.

A. Inspection, auditing or copying of records.

Each lottery retailer shall make all books and records pertaining to his lottery activities available for inspection, auditing or copying as required by the director between the hours of 8 a.m. and 5 p.m., Mondays through Fridays and during the normal business hours of the licensed retailer.

B. Records subject to seizure.

All books and records pertaining to the licensed retailer's lottery activities may be seized with good cause by the director without prior notice.

§ 2.17. Audit of records.

The director may require a lottery retailer to submit to the department an audit report conducted by an independent certified public accountant on the licensed

retailer's lottery activities. The retailer shall be responsible for the cost of only the first such audit in any one license term.

§ 2.18. Reporting requirements and settlement procedures.

Instructions for ordering on-line terminal ticket roll stock, reporting transactions and settling accounts. Before a retailer may begin lottery sales, the director will issue to him instructions and report forms that specify the procedures for (i) ordering on-line terminal ticket roll stock; (ii) reporting receipts, transactions and disbursements pertaining to on-line lottery ticket sales; and (iii) settling the retailer's account with the department.

§ 2.19. Training of retailers and their employees.

Retailer training. Each retailer or anyone that operates an on-line terminal at the retailer's location will be required to participate in training given by the department for the operation of each game. The director may consider nonparticipation in the training as grounds for suspending or revoking the retailer's license.

§ 2.20. License termination by retailer.

Voluntary termination of license. The licensed retailer may voluntarily terminate his license with the department by first notifying the department in writing at least 30 calendar days before the proposed termination date. The department will then notify the retailer of the date by which settlement of the retailer's account will take place. The retailer shall maintain his bond and the required accounts and records until settlement is completed and all lottery property belonging to the department has been surrendered.

PART III.
ON-LINE TICKET VALIDATION REQUIREMENTS.

§ 3.1. Validation requirements.

To be valid, a Virginia lottery on-line game ticket shall meet all of the validation requirements listed here:

1. The original ticket must be presented for validation.

2. The ticket validation number shall be presented in its entirety and shall correspond using the computer validation file to the selected numbers printed on the ticket.

3. The ticket shall not be mutilated, altered, or tampered with in any manner. (see § 3.4)

4. The ticket shall not be counterfeited, forged, fraudulently made or a duplicate of another winning ticket.

5. The ticket shall have been issued by the department through a licensed on-line lottery retailer in an authorized manner.

6. The ticket shall not have been cancelled.

7. The ticket shall be validated in accordance with procedures for claiming and paying prizes. (see §§ 3.10 and 3.12)

8. The ticket data shall have been recorded in the central computer system before the drawing, and the ticket data shall match this computer record in every respect.

9. The player-selected items, the validation data, and the drawing date of an apparent winning ticket must appear on the official file of winning tickets and a ticket with that exact data must not have been previously paid.

10. The ticket may not be misregistered or defectively printed to an extent that it cannot be processed by the department.

11. The ticket shall pass any validation requirement contained in the rules published and posted by the director for the on-line game for which the ticket was issued.

12. The ticket shall pass all other confidential security checks of the department.

§ 3.2. Invalid ticket.

An on-line ticket which does not pass all the validation requirements listed in these regulations and any validation requirements contained in the rules for its on-line game is invalid. An invalid ticket is not eligible for any prize.

§ 3.3. Replacement of ticket.

The director may refund the purchase price of an invalid ticket. If a defective ticket is purchased, the department's only liability or responsibility shall be to refund the purchase price of the defective ticket.

§ 3.4. When ticket cannot be validated through normal procedures.

If an on-line ticket is partially mutilated or if the ticket cannot be validated through normal procedure but can still be validated by other validation tests, the director may pay the prize for that ticket.

§ 3.5. Director's decision final.

All decisions of the director regarding ticket validation shall be final.

§ 3.6. Prize winning tickets.

Prize winning on-line tickets are those that have been

validated in accordance with these regulations and the rules of the department and determined to be official prize winners. Criteria and specific rules for winning prizes shall be published for each on-line game and available for all players. Final validation and determination of prize winning tickets remain with the department.

§ 3.7. Unclaimed prizes.

A. ~~All~~ *Except for free ticket prizes, all* claims for on-line game winning tickets must be postmarked or received for payment as prescribed in these regulations within 180 days after the date of the drawing for which the ticket was purchased. In the event that the 180th day falls on a Saturday, Sunday or legal holiday, a claimant may redeem his prize-winning ticket on the next business day *only at a lottery regional office* .

B. Any on-line lottery *cash* prize which remains unclaimed after 180 days following the drawing which determined the prize shall revert to the State Literary Fund. *Cash prizes do not include free ticket prizes or other noncash prizes such as merchandise, vacations, admissions to events and the like.*

C. All claims for on-line game winning tickets for which the prize is a free ticket must be postmarked or received for redemption as prescribed in these regulations within 60 days after the date of the drawing for which the ticket was purchased. In the event that the 60th day falls on a Saturday, Sunday or legal holiday, a claimant may only redeem his prize-winning ticket for a free ticket at an on-line lottery retailer on or before the 60th day. Except for claims for free ticket prizes mailed to lottery headquarters and postmarked on or before the 60th day, claims for such prizes will not be accepted at lottery regional offices or headquarters after the 60th day.

§ 3.8. Using winners' names.

The department shall have the right to use the names of prize winners and the city, town or county in which they live. Photographs of prize winners may be used with the written permission of the winners. No additional consideration shall be paid by the department for this purpose.

§ 3.9. No prize paid to people under 18.

No prize shall be claimed by , *redeemed from* or paid to any individual under 18 years of age.

§ 3.10. Where prizes claimed.

Winners may claim on-line game prizes from any licensed on-line retailer or the department in the manner specified in these regulations. Licensed on-line retailers are authorized and required to make payment of all validated prizes of less than $600.

§ 3.11. Validating winning tickets.

Winning tickets shall be validated by the retailer or the department as set out in these regulations and in any other manner which the director may prescribe in the specific rules for each type of on-line game.

§ 3.12. How prize claim entered.

A prize claim shall be entered in the name of an individual person or legal entity. If the prize claimed is $600 or greater, the person or entity also shall furnish a tax identification number.

A. An individual shall provide his social security number if a claim form is required by these regulations. A nonresident alien shall furnish their Immigration and Naturalization Service Number. This I.N.S. number begins with an A and is followed by numerical data.

B. A claim may be entered in the name of an organization only if the organization is a legal entity and possesses a federal employer's identification number (FEIN) issued by the Internal Revenue Service. If the department or these regulations require that a claim form be filed, the FEIN must be shown on the claim form.

C. A group, family unit, club or other organization which is not a legal entity or which does not possess a FEIN may file Internal Revenue Service (IRS) Form 5754, "Statement by Person(s) Receiving Gambling Winnings," with the department. This form designates to whom winnings are to be paid and the person(s) to whom winnings are taxable.

D. A group, family unit, club or other organization which is not a legal entity or which does not possess a FEIN and which does not file IRS Form 5754 with the department shall designate ~~one individual~~ *the individuals* in whose ~~name~~ *names* the claim shall be entered and ~~that person's~~ *those persons'* social security ~~number~~ *numbers* shall be furnished.

§ 3.13. Right to prize not assignable.

No right of any person to a prize shall be assignable, except that:

1. The director may pay any prize to the estate of a deceased prize winner, and

2. The prize to which a winner is entitled may be paid to another person pursuant to an appropriate judicial order.

§ 3.14. No accelerated payments.

The director shall not accelerate payment of a prize for any reason.

§ 3.15. Liability ends with prize payment.

All liability of the Commonwealth, its officials, officers and employees, and of the department, the board, the director and employees of the department, terminates upon final payment of a lottery prize.

§ 3.16. Delay of payment allowed.

The director may refrain from making payment of the prize pending a final determination by the director, under any of the following circumstances:

1. If a dispute occurs or it appears that a dispute may occur relative to any prize;

2. If there is any question regarding the identity of the claimant;

3. If there is any question regarding the validity of any ticket presented for payment; or

4. If the claim is subject to any set-off for delinquent debts owed to any agency eligible to participate in the Set-Off Debt Collection Act, when the agency has registered such debt with the Virginia Department of Taxation and timely notice of the debt has been furnished by the Virginia Department of Taxation to the State Lottery Department. No liability for interest for such delay shall accrue to the benefit of the claimant pending payment of the claim.

§ 3.17. When installment prize payment may be delayed.

The director may, at any time, delay any installment in order to review a change in circumstance relative to the prize awarded, the payee, the claim, or any other matter that has been brought to the department's attention. All delayed installments shall be brought up to date immediately upon the director's confirmation. Delayed installments shall continue to be paid according to the original payment schedule after the director's decision is given.

§ 3.18. Ticket is bearer instrument.

A ticket that has been legally issued by a licensed lottery retailer is a bearer instrument until the ticket has been signed. The person who signs the ticket is considered the bearer of the ticket.

§ 3.19. Payment made to bearer.

Payment of any prize will be made to the bearer of the validated winning ticket for that prize upon submission of a prize claim form, if one is required, unless otherwise delayed in accordance with these regulations. If a validated winning ticket has been signed, the bearer may be required to present proper identification.

§ 3.20. Marking tickets prohibited; exceptions.

Marking of tickets in any way is prohibited except by a player to claim a prize or by the department or a retailer to identify or to void the ticket.

§ 3.21. Penalty for counterfeit, forged or altered ticket.

Forging, altering or fraudulently making any lottery ticket or knowingly presenting a counterfeit, forged or altered ticket for prize payment or transferring such a ticket to another person to be presented for prize payment is a Class 6 felony in accordance with the state lottery law.

§ 3.22. Lost, stolen, destroyed tickets.

The department is not liable for lost, stolen or destroyed tickets.

The director may honor a prize claim of an apparent winner who does not possess the original ticket if the claimant is in possession of information which demonstrates that the original ticket meets the following criteria and can be validated through other means. The exception does not apply to an on-line game ticket the prize for which is a free ticket.

1. The claim form and a photocopy of the ticket, or photocopy of the original claim form and ticket, are timely filed with the department;

2. The prize for which the claim is filed is an unclaimed winning prize as verified in the department's records;

3. The prize has not been claimed within the required redemption period; and

4. The claim is filed within 180 days of the drawing or within the redemption period, as established by game rules.

§ 3.23. Retailer to pay all prizes less than $600.

Prizes less than $600 shall be paid by any licensed on-line retailer, or by the department at the option of the ticket holder, or by the department when the ticket cannot be validated by the retailer.

§ 3.24. Retailers' prize payment procedures.

Procedures for prize payments by retailers are as follows:

1. Retailers may pay *cash* prizes in cash, by certified check, cashier's check, business check, or money order, or by any combination of these methods.

2. If a check for payment of a prize by a retailer to a claimant is denied for any reason, the retailer is subject to the same service charge for referring a debt to the department for collection and penalty payments that would apply if the check were made

payable to the department. A claimant whose prize check is denied shall notify the department to obtain the prize.

3. Retailers shall pay claims for all prizes under $600 during all normal business hours of the lottery retailer when the on-line terminal is operational and the ticket claim can be validated.

4. Prize claims shall be payable only at the location specified on the license.

5. The department will reimburse a retailer for prizes paid up to 180 days after the drawing date.

§ 3.25. When retailer cannot validate ticket.

If, for any reason, a retailer is unable to validate a prize winning ticket, the retailer shall provide the ticket holder with a department claim form and instruct the ticket holder on how to file a claim with the department.

§ 3.26. No reimbursement for retailer errors.

The department shall not reimburse retailers for prize claims a retailer has paid in error.

§ 3.27. Retailer to void winning ticket.

After a winning ticket is validated and signed by the ticket holder, the retailer shall physically void the ticket to prevent it from being redeemed more than once. The manner of voiding the ticket will be prescribed by the director.

§ 3.28. Prizes of less than $600.

A retailer shall pay on-line prizes of less than $600 won on tickets validated and determined by the department to be official prize winners, regardless of where the tickets were sold. The retailer shall display special informational material provided by or approved by the department informing the public that the retailer pays all prizes of less than $600.

§ 3.29. When prize shall be claimed from the department.

The department will process claims for payment of prizes in any of the following circumstances:

1. If a retailer cannot validate a claim which the retailer otherwise would pay, the ticket holder shall ~~send or~~ present the *signed* ticket *and a completed claim form* to the department ~~for validation with a completed claim form~~ *regional office or mail both the signed ticket and a completed claim form to the department central office* .

2. If a ticket holder is unable to return to any on-line retailer ~~; a completed claim form and the ticket may be presented~~ *to claim a prize which the retailer otherwise would pay, the ticket holder may present the signed ticket at any department regional office* or ~~mailed~~ *mail both the signed ticket and a completed claim form* to the department ~~for validation~~ *central office* .

3. If the prize amount is $600 or more, *the ticket holder may present the signed ticket and* a completed claim form ~~with the ticket shall be presented~~ *at any department regional office* or ~~mailed~~ *mail both the signed ticket and a completed claim form* to the department ~~for validation~~ *central office* .

§ 3.30. Prizes of $25,000 or less.

Prizes of $25,000 or less may be claimed from any of the department's regional offices. Regional offices will pay prizes by check after tickets are validated and after any other applicable requirements contained in these regulations are met.

§ 3.31. Prizes of more than $25,000.

Prizes of more than $25,000 and noncash prizes other than free lottery tickets may be claimed from the department's central office in Richmond. The central office will pay *cash* prizes by check, after tickets are validated and after any other applicable requirements contained in these regulations are met.

§ 3.32. Grand prize event.

If an on-line game includes a grand prize or jackpot event, the following general criteria shall be used:

1. Entrants in the event shall be selected from tickets which meet the criteria stated in specific game rules set by the director consistent with § 1.1 of these regulations.

2. Participation in the drawing(s) shall be limited to those tickets which are actually purchased by the entrants on or before the date announced by the director.

3. If, after the event is held, the director determines that a ticket should have been entered into the event, the director may place that ticket into a grand prize drawing for the next equivalent event. That action is the extent of the department's liability.

4. The director shall determine the date(s), time(s) and procedures for selecting grand prize winner(s) for each on-line game. The proceedings for selection of the winners shall be open to members of the news media and to either the general public or entrants or both.

§ 3.33. When prize payable over time.

Unless the rules for any specific on-line game provide

otherwise, any cash prize of ~~$500,000~~ *$100,001* or more will be paid in multiple payments over time. The schedule of payments shall be designed to pay the winner equal dollar amounts ~~over a period of years~~ *in each year, with the exception of the first,* until the total payments equal the prize amount.

§ 3.34. Rounding total prize payment.

When a prize or share is to be paid over time, except for the first payment, the director may round the actual amount of the prize or share to the nearest $1,000 to facilitate purchase of an appropriate funding mechanism.

§ 3.35. When prize payable for "life."

If a prize is advertised as payable for the life of the winner, only an individual may claim the prize. If a claim is filed on behalf of a group, company, corporation or any other type of organization, the life of the claim shall be 20 years.

§ 3.36. When claims form required.

A claim form for a winning ticket may be obtained from any department office or any licensed lottery retailer. A claim form shall be required to claim any prize from the department's central office. A claim form shall be required to claim any prize of $600 or more from the department's regional offices.

§ 3.37. Department action on claims for prizes submitted to department.

The department shall validate the winning ticket claim according to procedures contained in these regulations as follows:

1. If the claim is not valid, the department will promptly notify the ticket holder.

2. If the claim is mailed to the department and the department validates the claim, a check for the prize amount will be mailed to the winner.

3. If an individual presents a claim to the department in person and the department validates the claim, a check for the prize amount will be presented to the bearer.

§ 3.38. Withholding, notification of prize payments.

When paying any prize of $600 or more, the department shall:

1. File the appropriate income reporting form(s) with the Virginia Department of Taxation and the Federal Internal Revenue Service;

2. Withhold any moneys due for delinquent debts listed with the Commonwealth's Set-Off Debt Collection Program; and

3. Withhold federal and state taxes from any winnings over $5,000.

§ 3.39. Director may postpone drawing.

The director may postpone any drawing to a certain time and publicize the postponement if he finds that the postponement will serve and protect the public interest.

* * * *

NOTICE: The forms used in administering the On-Line Game Regulations are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the State Lottery Department, 2201 West Broad Street, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

On-Line Game Survey (SLD-120)
Retailer Data Collection
On-Line License Approval Notice
Lottery Retailer Surety Bond
Retailer Agreement Form (SLD-130, 3/89)
Virginia Lottery Licensed Retailer Certificate (4/90)
Request for Inactivating Retailer Terminal (X-0118, 6/89)
Things to Do
Bond Continuation Certificate (letter)
Commonwealth of Virginia Lottery Bond Application
Special Notice on Bonding for Lottery Retailers
Security Check (X-0077, 2/89)
Virginia Lottery On-Line Play Center; Agreement/Order Form (SLD-0136, 4/89)
Ticket Stock Central Distribution Form (X-0095, 6/89)
Ticket Stock Regional Distribution Form (X-0133, 6/89)
On-Line Ticket Stock Return (X-0120, 6/89)
On-Line Ticket Stock Destruction Form (X-0121, 6/89)
Seal Verification Chart - Pick 3/4 (X-0103, 6/89)
Draw Verification Sheet (SLD-0137, 4/89)
On-Line Weekly Settlement Envelope (SLD-0127)
Weekly Settlement Form
A/R Online Accounting Transaction Form (X-0105, 6/89)
Cash Tickets Envelope/Cancelled Tickets Envelope
Ticket Problem Report
Hot Line Report (X-0079, 2/89)
Winner Claim Form (SLD-0007, 3/89)
Winner-Gram (SLD-0016)

DEPARTMENT OF TAXATION

Tax Bulletin 91-1

DATE: February 26, 1991

SUBJECT: 1990 Individual Income Tax: Age Subtraction

The 1991 General Assembly retroactively changed the computation of the age subtraction for a limited number of taxpayers age 62 and over.

This change affects only those taxpayers who (1) receive Social Security and/or Tier 1 Railroad Retirement Act benefits, and (2) are:

- Age 62-64 with federal adjusted gross income (FAGI) of less than $6,000, or
- Age 65 and over with FAGI of less than $12,000.

No other taxpayers age 62 and over are affected by this change.

The change is effective for all taxable year 1990 returns, including returns already filed.

New Computation of the Age Subtraction

Taxpayers age 62-64 with FAGI less than $6,000 or age 65 and over with FAGI less than $12,000, should disregard the instruction for Line 31 (only) of the 1990 Form 760 and compute the subtraction as follows:

- Line 31: Enter on this line your and your spouse's FAGI plus Social Security and Tier 1 Railroad Retirement Act benefits received.
- Lines 32-35: Compute as currently instructed.
- Note: If a part-year resident or nonresident, see page 2.

Effect of Change/Examples

The following examples on page 2 illustrate the change:

Example 1: A 70-year old taxpayer has FAGI of $8,000 and Social Security of $9,000.

Line 31	FAGI + Social Security	$17,000
Line 32	Maximum subtraction amount	$12,000
Line 33	Subtraction base (lesser of lines 31 and 32)	$12,000
Line 34	Sum of Social Security and Tier 1 Railroad Retirement	$ 9,000
Line 35	Subtraction (Line 33 - Line 34)	$ 3,000

Examples 2: A 63-year old taxpayer has FAGI of $5,500 and Social Security of $4,500.

Line 31	FAGI + Social Security	$10,000
Line 32	Maximum subtraction amount	$ 6,000
Line 33	Subtraction base (lesser of lines 31 and 32)	$ 6,000
Line 34	Sum of Social Security and Tier 1 Railroad Retirement	$ 4,500
Line 35	Subtraction (Line 33 - Line 34)	$ 1,500

How to Take Advantage of the Change

If you have not filed your 1990 return, use the instructions on page 1 of this bulletin to compute the age subtraction. As long as you fully complete Part 1 (lines 31-35) of Form 760, the department will verify that you correctly computed the subtraction.

If you have already filed your 1990 return and fully completed Part I, the department will recompute your age subtraction automatically. Where this results in a lower tax, the department will issue you a refund.

If you have already filed your 1990 return but did not fully complete Part I, you will need to file an amended return. To assist the department, please note at the top of the amended return "RECOMPUTED AGE SUBTRACTION."

Nonresidents and Part-year Residents

Nonresidents should complete Schedule NPY, Part I as instructed except for line 1, where they need to enter their FAGI plus Social Security and Tier 1 Railroad Retirement benefits.

Part-year residents should fill out Schedule NPY, Part 1 as instructed, except as follows:

- Lines 1 and 6A should reflect FAGI plus Social Security and Tier 1 Railroad Retirement benefits (line 1 showing amounts received while a Virginia resident and Line 6A showing total amounts received).
- The percentage computed on line 8 should be based on FAGI received while a Virginia resident divided by total FAGI (do not include Social Security or Railroad Retirement Act benefits in computation).

GOVERNOR'S COMMENTS ON PROPOSED REGULATIONS

(Required by § 9-6.12:9.1 of the Code of Virginia)

BOARD FOR GEOLOGY

Title of Regulation: **VR 335-01-2. Virginia Board for Geology Regulations.**

Governor's Comment:

The proposed regulations, in accordance with the Callahan Act, would enable the Board for Geology to cover administrative expenses. Pending public comment, I recommend approval.

/s/ Lawrence Douglas Wilder
Governor
Date: February 26, 1991

STATE LOTTERY DEPARTMENT

Title of Regulation: **VR 447-01-2. Administration Regulations.**

Governor's Comment:

By revising procurement procedures substantially, the proposal's intent is to allow more flexibility in purchasing goods and services. Pending public comment, I recommend approval.

/s/ Lawrence Douglas Wilder
Governor
Date: March 11, 1991

* * * * * * * *

Title of Regulation: **VR 447-02-1. Instant Game Regulations.**

Governor's Comment:

The intent of this proposal is to refine the licensing procedure and to promulgate an amendment approved as an emergency regulation. Pending public comment, I recommend approval.

/s/ Lawrence Douglas Wilder
Governor
Date: February 26, 1991

* * * * * * * *

Title of Regulation: **VR 447-02-2. On-Line Game Regulations.**

Governor's Comment:

The proposal is intended to provide new services and refine the licensing procedure. Pending public comment, I recommend approval.

/s/ Lawrence Douglas Wilder
Governor
Date: February 26, 1991

DEPARTMENT OF SOCIAL SERVICES

Title of Regulation: **VR 615-01-34. Aid to Dependent Children - Unemployed Parent Program (ADC-UP) Program - Limitation of Assistance.**

Governor's Comment:

I concur with the form and the content of this proposal. My final approval will be contingent upon a review of the public's comments.

/s/ Lawrence Douglas Wilder
Governor
Date: Feburary 25, 1991

* * * * * * * *

Title of Regulation: **VR 615-01-35. Monthly Reporting in the Food Stamp Program.**

Governor's Comment:

I concur with the form and the content of this proposal. My final approval will be contingent upon a review of the public's comments.

/s/ Lawrence Douglas Wilder
Governor
Date: Feburary 25, 1991

* * * * * * * *

Title of Regulation: **VR 615-22-02. Standards and Regulations for Licensed Homes for Adults.**

Governor's Comment:

I concur with the form and the content of this proposal. My final approval will be contingent upon a review of the public's comments.

/s/ Lawrence Douglas Wilder
Governor
Date: Feburary 22, 1991

DEPARTMENT OF WASTE MANAGEMENT

Title of Regulation: **VR 672-10-1. Hazardous Waste Management Regulations.**

Governor's Comment:

These regulations are proposed to ensure that Virginia's regulations are consistent with federal statutes and regulations. Pending public comment, I recommend approval.

/s/ Lawrence Douglas Wilder
Governor
Date: February 26, 1991

BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS

Title of Regulation: **VR 675-01-02. Board for Waterworks and Wastewater Works Operators Regulations.**

Governor's Comment:

The proposed regulations, in accordance with the Callahan Act, would enable the Board for Waterworks and Wastewater Works Operators to cover administrative expenses. Pending public comment, I recommend approval of the regulations.

/s/ Lawrence Douglas Wilder
Governor
Date: February 27, 1991

Symbol Key †
† Indicates entries since last publication of the Virginia Register

STATE AIR POLLUTION CONTROL BOARD

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Air Pollution Contol Board intends to consider amending regulations entitled: **VR 120-01. Regulations for the Control and Abatement of Air Pollution.** The purpose of the proposed action is to provide the latest edition of referenced technical and scientific documents and to incorporate newly promulgated federal New Source Performance Standards and National Emission Standards for Hazardous Air Pollutants.

A public meeting will be held on April 24, 1991, at 10 a.m. in House Room 1, State Capitol Building, Richmond, Virginia, to receive input on the development of the proposed regulation.

Statutory Authority: § 10.1-1308 of the Code of Virginia.

Written comments may be submitted until April 24, 1991, to Director of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240.

Contact: Nancy S. Saylor, Policy Analyst, Division of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240, telephone (804) 786-1249.

ALCOHOLIC BEVERAGE CONTROL BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Alcoholic Beverage Control Board intends to consider amending regulations of the Alcoholic Beverage Control Board entitled:

VR 125-01-01. Procedural Rules for the Conduct of Hearings Before the Board and its Hearing Officers and the Adoption or Amendment of Regulations.
VR 125-01-02. Advertising.
VR 125-01-03. Tied House.
VR 125-01-04. Requirements for Product Approval.
VR 125-01-05. Retail Operations.
VR 125-01-06. Manufacturers and Wholesalers Operations.
VR 125-01-07. Other Provisions.

The purpose of the proposed action is to receive information from industry, the general public and licensees of the board concerning adopting, amending or repealing the board's regulations. A public meeting will be held on June 20, 1991, at 10 a.m. in the First Floor Hearing Room, 2901 Hermitage Road, Richmond, Virginia, to receive comments from the public (See notice in General Notices Section.)

Statutory Authority: §§ 4-7(1), 4-11, 4-36, 4-69, 4-69.2, 4-72.1, 4-98.14, 4-103(b) and 9-6.14:1 et seq. of the Code of Virginia.

Written comments may be submitted until April 18, 1991.

Contact: Robert N. Swinson, Secretary to the Board, P.O. Box 27491, Richmond, VA 23261, telephone (804) 367-0616.

CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Chesapeake Bay Local Assistance Board intends to consider amending regulations entitled: **VR 173-02-01. Chesapeake Bay Preservation Area Designation and Management Regulations.** The purposes of the proposed action are to:

1. Compress deadlines for adoption of local programs pursuant to the Chesapeake Bay Preservation Act (§ 10.1-2100 et seq. of the Code of Virginia) from two separate and consecutive one-year adoption periods for various parts of the program into a single one-year adoption period for all parts of the program;

2. Clarify the kinds of roads and streets exempted as "public roads" by § 4.5 B 1 of the regulations, and establish conditions which roads, streets and driveways must satisfy in order to cross Resource Protection Areas;

3. Establish a specific date of subdivision for exempting lots that cannot comply with buffer area and reserve septic system drainfield requirements; and

4. Change the effective date of the regulations in order to supersede Emergency Regulations (VR 173-02-01.1) adopted by the Board on November 15, 1990, and amended and readopted on December 3, 1990, and approved by the Governor. The emergency regulations already incorporate the compression of local program adoption deadlines and the buffer and reserve drainfield effective date proposed in Nos. 1 and 3 above.

Statutory Authority: §§ 10.1-2103 and 10.1-2107 of the Code of Virginia.

Written comments may be submitted until 5 p.m., March 27, 1991.

Contact: Scott Crafton, Regulatory Assistance Coordinator, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7729.

DEPARTMENT OF CORRECTIONS (STATE BOARD OF)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Corrections intends to consider amending regulations entitled: **VR 230-20-001. Operational Standards for Adult Institutions.** The purpose of the proposed action is to establish minimum operations standards for adult institutions of the Department of Corrections.

Statutory Authority: § 53.1-5 of the Code of Virginia.

Written comments may be submitted until May 15, 1991.

Contact: John T. Britton, Manager, Certification and Research, P.O. Box 26963, Richmond, VA 23261, telephone (804) 674-3237.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Corrections intends to consider amending regulations entitled: **VR 230-30-006. Jail Work/Study Release Program Standards.** The purpose of the proposed action is to establish minimum standards for the establishment and operation of a jail work/study release program.

Statutory Authority: § 53.1-131 of the Code of Virginia.

Written comments may be submitted until May 15, 1991.

Contact: A. T. Robinson, Local Facilities Administrator, P.O. Box 26963, Richmond, VA 23261, telephone (804) 674-3251.

DEPARTMENT OF EDUCATION (STATE BOARD OF)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Education intends to consider promulgating regulations entitled: **Licensure Regulations for School Personnel.** The primary purpose for licensing school personnel is to maintain standards of professional competence.

The existing Certification Regulations for Teachers, effective July 1, 1986, and the addendum to the regulations effective October 22, 1987, shall be repealed. Licensure regulations shall be promulgated as a result of the Board of Education's mandates to restructure preparation programs for teachers and administrators. The new regulations are substantially different in form and content.

Statutory Authority: §§ 22.1-298 and 22.1-299 of the Code of Virginia.

Written comments may be submitted until April 8, 1991.

Contact: Patty S. Pitts, Associate Specialist, Teacher Certification, Virginia Department of Education, P.O. Box 6Q, Richmond, VA 23216-2060, telephone (804) 225-2098.

COUNCIL ON THE ENVIRONMENT

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Council on the Environment intends to consider promulgating regulations entitled: **Public Participation Guidelines.** The purpose of the proposed action is to establish public participation guidelines governing the Council on the Environment.

Statutory Authority: §§ 10.1-1206 and 62.1-195.1 of the Code of Virginia.

Written comments may be submitted until March 29, 1991.

Contact: Jay Roberts, Environmental Planner, 202 N. Ninth St., Suite 900, Richmond, VA 23219, telephone (804) 786-4500.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Council on the Environment intends to consider promulgating regulations entitled: **Guidelines for the Preparation of Environmental Impact Assessments for Oil or Gas Well Drilling Operations in Tidewater Virginia.** The purpose of the proposed action is to promulgate criteria and procedures for preparing environmental impact assessments required for oil or gas well drilling activities in Tidewater Virginia.

State law requires that persons intending to drill for oil or gas in any area of Tidewater Virginia (defined in § 62.1-13.2 of the Code of Virginia) shall submit to the Department of Mines, Minerals and Energy, as part of the permit application to drill, an environmental impact assessment (EIA). The EIA must include a discussion of:

1. The probabilities and consequences of accidental discharges of oil or gas to the environment during drilling, production and transportation on:

a. Finfish, shellfish and other marine and freshwater organisms,

b. Birds and other wildlife,

c. Air and water quality, and

d. Land and water resources;

2. Recommendations for minimizing any adverse economic, fiscal or environmental impacts; and

3. An examination of the secondary environmental effects of induced economic development during drilling and production.

The content of an EIA is governed by the statute cited below. A copy of the statute may be obtained by contacting the person indicated below.

The Council on the Environment will hold a meeting to gather information on and to receive comments on issues related to the development of this regulation on March 5, 1991, beginning at 9 a.m. in Senate Room 4, State Capitol Building, Richmond, Virginia.

Statutory Authority: §§ 10.1-1206 and 62.1-195.1 of the Code of Virginia.

Written comments may be submitted until March 29, 1991.

Contact: Jay Roberts, Environmental Planner, 202 N. Ninth St., Suite 900, Richmond, VA 23219, telephone (804) 786-4500.

BOARD FOR GEOLOGY

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board for Geology intends to consider amending regulations entitled: **VR 335-01-2. Virginia Board for Geology Rules and Regulations.** Biannual regulatory review.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Written comments may be submitted until April 8, 1991.

Contact: Nelle P. Hotchkiss, Assistant Director, Asbestos Licensing Program, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595.

DEPARTMENT OF HEALTH (STATE BOARD OF)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Health intends to consider amending regulations entitled: **VR 355-30-01. Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.** The purpose of the proposed action is to amend the existing Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations so that the regulations are consistent with the amended law.

Statutory Authority: § 32.1-12 of the Code of Virginia.

Written comments may be submitted until April 23, 1991.

Contact: Wendy V. Brown, Acting Director, Division of Resources Development, Virgina Department of Health, 1500 East Main St., Suite 105, Richmond, VA 23219, telephone (804) 786-7463.

VIRGINIA HEALTH SERVICES COST REVIEW COUNCIL

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Virginia Health Services Cost Review Council intends to consider amending regulations entitled: **VR 370-01-001. Rules and Regulations of the Virginia Health Services Cost Review Council.** The purpose of the proposed action is to clarify that health care institutions as defined by § 9-156 of the Code of Virginia that are part of continuing care retirement centers have licensed home for adult beds or have licensed nursing home beds as part of a hospital, and must segregate the patient care activities provided in its nursing home component from its nonpatient care activities when completing the report forms required by Council.

Statutory Authority: §§ 9-158 and 9-164 of the Code of Virginia.

Written comments may be submitted until April 15, 1991.

Contact: G. Edward Dalton, Deputy Director, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371.

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT (BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Housing and Community Development intends to consider amending regulations entitled: **VR 394-01-06. Virginia Statewide Fire Prevention Code/1990.** The purpose of the proposed action is to establish a fee schedule for explosive permits issued by the Professional Services Office.

Statutory Authority: § 27-97 of the Code of Virginia.

Written comments may be submitted until April 12, 1991.

Contact: Gregory H. Revels, Program Manager, Department of Housing and Community Development, Code Development Office, 205 N. Fourth St., Richmond, VA 23219, telephone (804) 786-4884.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Housing and Community Development intends to consider amending regulations entitled: **VR 394-01-21. Virginia Uniform Statewide Building Code, Volume I - New Construction Code/1990.** The purpose of the proposed action is to amend floodproofing provisions to be consistent with the National Flood Insurance Program administered by the Federal Emergency Management Agency.

Statutory Authority: §§ 36-981 and 36-99 of the Code of Virginia.

Written comments may be submitted until April 11, 1991.

Contact: Gregory H. Revels, Code Development Program Manager, Department of Housing and Community Development, 205 N. Fourth St., Richmond, VA 23219, telephone (804) 786-7772.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medical Assistance Services intends to consider amending regulations entitled: **OBRA 89 Requirements for EPSDT.** The purpose of the proposed action is to implement the OBRA 89 requirements for the Early and Periodic Screening, Diagnosis and Treatment Program.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until April 12, 1991, to Scott Crawford, Policy Analyst, Division of Policy and Research, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medical Assistance Services intends to consider amending regulations entitled: **Payment for Other Types of Care (Attachment 4.19 B): Reduction of Payment for Nonemergency Services Delivered in Emergency Rooms to Medicaid Recipients.** The purpose of the proposed action is to reduce payments to physicians and hospitals for the delivery of nonemergency services in the emergency room setting.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until April 22, 1991, to Michael Jurgensen, Division of Policy and Research, Deparment of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, Virginia.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

BOARD OF MEDICINE

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Medicine intends to consider amending regulations entitled: **VR 465-03-01. Regulations Governing the Practice of Physical Therapy.** The purpose of the proposed action is to amend the definitions to define the home/extended care facilities or institutions in which physical therapy services are provided, and to amend § 5.3 Supervision of trainership and § 6.1 Supervision of physical therapist assistants.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Written comments may be submitted until March 25, 1991, to Board of Medicine, 1601 Rolling Hills Drive, Richmond, VA 23229-5005.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229-5005, telephone (804) 662-9925.

BOARD OF NURSING AND BOARD OF MEDICINE

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Nursing and Board of Medicine intends to consider amending regulations entitled: **VR 465-07-1 and 495-02-1. Regulations Governing the Licensure of Nurse Practitioners.** The purpose of the proposed action is to establish standards on education, licensure and practice of nurse practitioners. The Boards of Nursing and Medicine will propose amendments as necessary following a biennial review for effectiveness, efficiency, necessity, clarity and cost of compliance. A public meeting to receive oral comments on existing regulations will be held on April 5, 1991, at 1:30

p.m. in Conference Room 1, Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

Statutory Authority: §§ 54.1-2400 and 54.1-2957 of the Code of Virginia.

Written comments may be submitted until April 30, 1991.

Contact: Corrine F. Dorsey, Executive Director, Board of Nursing, 1601 Rolling Hills Dr., Richmond, VA 23229-5005, telephone (804) 662-9909 or toll-free 1-800-533-1560.

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Social Services intends to consider amending regulations entitled: **General Relief (GR) and Auxiliary Grants (AG) Programs - Attempted Recovery of Overpayments.** The purpose of the proposed action is to require that local departments of social services attempt to recover overpayments of $94 or more in General Relief and Auxiliary Grants cases.

Statutory Authority: § 63.1-25 of the Code of Virginia.

Written comments may be submitted until April 10, 1991, to Ms. Diana Salvatore, Program Manager, Medical Assistance Unit, Division of Benefit Programs, Department of Social Services, 8007 Discovery Drive, Richmond, Virginia.

Contact: Peggy Friedenberg, Legislative Analyst, Bureau of Governmental Affairs, Division of Planning and Program Review, 8007 Discovery Drive, Richmond, VA 23229-0899, telephone (804) 662-9217.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Social Services intends to consider amending regulations entitled: **General Relief (GR) and Auxiliary Grants (AG) Programs - Services Included in the Home for Adults Rate.** The purpose of the proposed action is to specify the services that are covered by the rate established by the department for a Home for Adults (HFA) so that GR/AG recipients do not pay extra for those services.

Statutory Authority: § 63.1-25 of the Code of Virginia.

Written comments may be submitted until April 10, 1991, to Ms. Diana Salvatore, Program Manager, Medical Assistance Unit, Division of Benefit Programs, Department of Social Services, 8007 Discovery Drive, Richmond, Virginia.

Contact: Peggy Friedenberg, Legislative Analyst, Bureau of Governmental Affairs, Division of Planning and Program Review, 8007 Discovery Drive, Richmond, VA 23229-0899, telephone (804) 662-9217.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Social Services intends to consider amending regulations entitled: **The Virginia Energy Assistance Program.** The department is planning to utilize policies and procedures implemented in the 1990-1991 Energy Assistance Program for the 1991-92 Energy Assistance Program. The department is reviewing a proposal to begin the Fuel Assistance and Crisis Assistance Components on December 1, 1991.

Statutory Authority: § 63.1-25 of the Code of Virginia.

Written comments may be submitted until March 25, 1991.

Contact: Charlene H. Chapman, Program Manager, Bureau of Energy and Emergency Assistance, Division of Benefit Programs, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229, telephone (804) 662-9727.

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Social Services intends to consider amending regulations entitled: **VR 615-42-2. Foster Care.** The purpose of the proposed action is to continue foster care services beyond a child's eighteenth birthday.

Statutory Authority: § 63.1-25 of the Code of Virginia.

Written comments may be submitted until April 11, 1991, to Pamela T. Fitzgerald, Department of Social Services, 8007 Discovery Drive, Richmond, Virginia.

Contact: Margaret J. Friedenberg, Regulatory Coordinator, 8007 Discovery Drive, Richmond, VA 23229-0899, telephone (804) 662-9217.

GENERAL NOTICES

DEPARTMENT FOR THE AGING

† Notice of Public Comment Period on 1991-95 State Plan for Aging Services

Notice is hereby given that the Department for the Aging will accept comments on the proposed State Plan for Aging Services developed pursuant to Title III of the Older Americans Act, as amended. Interested persons may submit data, views, and arguments, either orally or in

writing, to the Deparment.

The State Plan for Aging Services will (i) identify the Virginia Department for the Aging as the sole agency designated to develop and administer Title III programs in Virginia; (ii) identify the geographic boundaries of each Planning and Service Area in Virginia and the Area Agency on Aging designated for each Planning and Service Area; (iii) include a plan for the distribution and proposed use of Title III funds within Virginia; (iv) set forth statewide program objectives to implement the requirements of Title III; and (v) provide prior federal fiscal year information related to low-income minority and rural older persons in Virginia. The Plan is for the four-year period from October 1, 1991, through September 30, 1995. The Department anticipates submitting the Plan to the Federal Administration on Aging in August, 1991.

Five public hearings will be held on the Plan. Persons who testify at the hearings are encouraged to provide a written copy of their comments to the hearing officer. An interpreter for the hard-of-hearing will be provided upon request.

June 4, 1991

Southwest Virginia Community College
Russell Hall Audtiorium
Richlands, Virginia
10 a.m. - 12 p.m.

June 5, 1991
Melrose Towers
3038 Melrose Avenue NW
Roanoke, Virginia
10 a.m. - 12 p.m.

June 12, 1991
Richard Bland College
11301 Johnson Road
Petersburg, Virginia
10 a.m. - 12 p.m.

June 13, 1991
Norfolk State University
2401 Corprew Avenue
Norfolk, Virginia
10 a.m. - 12 p.m.

June 26, 1991
The Massey Building
4100 Chain Bridge Road
Fairfax, Virginia
10 a.m. - 12 p.m.

Written comments on the Plan may be submitted until 5 p.m. on June 28, 1991. Comments should be sent to: Mr. William H. McElveen, Deputy Commissioner, Virginia Department for the Aging, 700 East Franklin Street, 10th Floor, Richmond, Virginia 23219-2327.

To receive a copy of the proposed State Plan and to obtain further information, write to the Department of the Aging at the address above or call 804-225-2271 or toll-free in Virginia 1-800-552-04464.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

† Notice to the Public

The Pesticide Control Board has decided to extend the deadline for receipt of public comment on proposed amendments to VR 115-04-03, Rules and Regulations for Enforcement of the Virginia Pesticide Law; and on proposed regulation VR 115-04-23, Regulations Governing Pesticide Applicator Certification under Authority of Virginia Pesticide Control Act. The deadline for receipt of written comment specified for these proposed regulations published in the Virginia Register of Regulations (Volume 7, Issue 11, pp. 1745-1748) and in the Richmond Times-Dispatch on February 25, 1991 is hereby extended to 5 p.m., May 17, 1991. The public hearing will be held at the date, time, and place advertised on February 25 in those publications.

Comments may be addressed to:

Dr. Marvin A. Lawson
Office of Pesticide Management
Department of Agriculture and Consumer Services
1100 Bank Street, Room 403
Richmond, Virginia 23209
Telephone: (804) 371-6558; FAX (804) 371-8598.

† Notice to the Public

RECORD HELD OPEN ON PROPOSED AMENDMENT TO VR 115-04-04, RULES AND REGULATIONS FOR THE ENFORCEMENT OF THE VIRGINIA WEIGHTS AND MEASURES LAW

At its meeting of February 20, 1991, the Board of Agriculture and Consumer Services decided to hold the record open to receive additional public comment on its proposed amendment to VR 115-04-04, Rules and Regulations for the Enforcement of the Virginia Weights and Measures Law, proposed in the Virginia Register on January 29, 1990 (Vol 6, Issue 9, pp. 1235 ff.). This proposed amendment would establish a method of sale and standards of fill, as determined by weight, for clams, mussels, oysters, and other mollusks.

The Board's decision to hold the record open came after it received a report from the Board's staff of a survey, requested by the Board, of the free-liquid content of oysters and other mollusks offered for retail sale in Virginia. The survey is entitled "Oyster Standards Survey – September 1, 1990 - January 31, 1991.

For further information, to receive a copy of the survey,

or to comment on the proposed regulation or the survey, contact:

J. Alan Rogers
Bureau Chief
Weights and Measures Bureau
Washington Building
Room 402
1100 Bank Street
P.O. Box 1163
Richmond, Virginia 23209
(804) 786-2476

The deadline for additional oral or written comment is 5 p.m., April 29, 1991. The Board will hold an informational proceeding on the proposed amendment to the regulation on May 23, 1991, beginning at 1 p.m.

DEPARTMENT OF ALCOHOLIC BEVERAGE CONTROL

Public Notice

A. Pursuant to the Virginia Alcoholic Beverage Control Board's "Public Participation Guidelines for Adoption or Amendment of Regulations" (VR 125-01-1, Part V of the Regulations of the Virginia Alcoholic Beverage Control Board), the board will conduct a public meeting on June 20, 1991, at 10 a.m. in its Hearing Room, First Floor, A.B.C. Board, Main Offices, 2901 Hermitage Road, City of Richmond, Virginia, to receive comments and suggestions concerning the adoption, amendment or repeal of board regulations. Any group or individual may file with the board a written petition for the adoption, amendment or repeal of any regulation. Any such petition shall contain the following information, if available.

1. Name of petitioner.

2. Petitioner's mailing address and telephone number.

3. Recommended adoption, amendment or repeal of specific regulation(s).

4. Why is change needed? What problem is it meant to address?

5. What is the anticipated effect of not making the change?

6. Estimated costs or savings to regulate entities, the public, or others incurred by this change as compared to current regulations.

7. Who is affected by recommended change? How affected?

8. Supporting documents.

The board may also consider any other request for regulatory change at its discretion. All petitions or requests for regulatory change should be submitted to the board no later than April 18, 1991.

B. The board will also be appointing an Ad Hoc Advisory Panel consisting of persons on its general mailing list who will be affected by or interested in the adoption, amendment or repeal of board regulations. This panel will study requests for regulatory changes, make recommendations, and suggest actual draft language for a regulation, if it concludes a regulation is necessary. Anyone interested in serving on such panel should notify the undersigned by April 18, 1991, requesting that their name be placed on the general mailing list.

C. Petitions for regulatory change and requests to be appointed to the Ad Hoc Advisory Panel should be sent to Robert N. Swinson, Secretary to the Board, 2901 Hermitage Road, Richmond, Virginia 23220 or may be faxed (804) 367-8249 if the original paperwork is also mailed.

D. Applicable laws or regulation (authority to adopt regulations): Sections 4-11, 4-69, 4-69.2, 4-72.1, 4-98.4, 4-103 and 9-6.14:1 et seq., Virginia Code; VR 125-01-1, Part V, Board Regulations.

E. Entities affected: (1) all licensees (manufacturers, wholesalers, importers, retailers) and (2) the general public.

F. For further information contact Robert Swinson at the above address or by phone at (804) 367-0616.

DEPARTMENT OF HEALTH PROFESSIONS

Informational Public Hearing on the Need for State Regulation of Therapeutic Recreation Specialists and Activity Professionals

As authorized by Code of Virginia § 54.1-2501.2 the Board of Health Professions is evaluating proposals for state regulation of two unregulated professions: (i) Therapeutic Recreation Specialists, and (ii) Activity Professionals. The board will evaluate these professions using seven formal criteria which are available on request.

The board will convene informational public hearings on Monday, April 15, 1991, at the Department of Health Professions, 1601 Rolling Hills Drive (Surry Building, Koger Executive Center, West), Richmond to hear comments from agencies, organizations and individuals regarding the two proposals.

4 p.m. - 6 p.m. - Therapeutic Recreation Specialists

6 p.m. - 8 p.m. - Activity Professionals

Oral comments should be limited to five minutes and may be accompanied or complemented with written materials. Written comments are also solicited and must be received by Friday, May 17, 1991, at the address below.

For additional information, travel directions, or to reserve a specific speaking time, please contact the Board of Health Professions (see below).

Contact: Richard Morrison, Executive Director, Department of Health Professions, 1601 Rolling Hills Dr., Suite 200, Richmond, VA 23229-5005, telephone (804) 662-9904.

DEPARTMENT OF LABOR AND INDUSTRY

† Notice to the Public

On January 8, 1991, the Virginia Safety and Health Codes Boards approved a final regulation entitled: VR 425-01-74, Licensed Asbestos Contractor Notification, Asbestos Project Permits, and Permit Fees. The effective date for this regulation is April 1, 1991, as approved by the Board.

Due to budgetary constraints, implementation of the requirements for payment of a fee and issuance of an Asbestos Project Permit under this regulation has been delayed until July 1, 1991.

Please note, however, that all other requirements of the regulation still become effective on April 1, 1991. After April 1, 1991, notification to the department must be made on the revised notification form prior to the initiation of any asbestos project.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

† Notice to the Public

State Plan for Medical Assistance

Notice of Significant Change in Statewide Methods and Standards for Setting Payment Rates

(Title 42 Code of Federal Regulations 447.205)

Regulation Title: Nursing Home Payment System: Patient Intensity Rating System.

Description: This change provides for the reimbursement methodology for nursing homes to conform a General Assembly mandate to achieve $2.2 million in additional General Fund savings during fiscal year 1992 through an adjustment of Medicaid reimbursement policies or rates for nursing home costs.

Estimate of Expected Changes in Annual Aggregate Expenditures: This methodology results in a State Plan amendment and projects a decrease to the agency's medical program in FY'92 of $4.4 million out of an annual total appropriation of $1.4 billion.

To comply with this mandate, the Department will amend effective April 1, 1991, the provisions of the Nursing Home Payment System regarding reimbursement policies or rates.

Why the Agency is Changing its Methods and Standards: The 1991 General Assembly, in the Appropriations Act, mandated that: The Secretary of Health and Human Resources shall achieve $2.2 million in additional General Fund savings in the second year through an adjustment of Medicaid reimbursement policies or rates for nursing home costs. The State Plan will be amended to conform to this requirement.

Availability of Proposed Changes and Address for Comments: Please request a copy of the regulations from and direct your written comments to: Victoria P. Simmons, Regulatory Coordinator, Deptartment of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219. Questions regarding the implementation of this policy may be directed to William R. Blakely, Director, Division of Cost Settlement and Audit at (804) 786-5590.

NOTICES TO STATE AGENCIES

CHANGE OF ADDRESS: Our new mailing address is: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219. You may FAX in your notice; however, we ask that you do not follow-up with a mailed in copy. Our FAX number is: 371-0169.

RE: Forms for filing material on dates for publication in the Virginia Register of Regulations.

All agencies are required to use the appropriate forms when furnishing material and dates for publication in the Virginia Register of Regulations. The forms are supplied by the office of the Registrar of Regulations. If you do not have any forms or you need additional forms, please contact: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

FORMS:

NOTICE of INTENDED REGULATORY ACTION - RR01
NOTICE of COMMENT PERIOD - RR02
PROPOSED (Transmittal Sheet) - RR03
FINAL (Transmittal Sheet) - RR04
EMERGENCY (Transmittal Sheet) - RR05
NOTICE of MEETING - RR06
AGENCY RESPONSE TO LEGISLATIVE OR GUBERNATORIAL OBJECTIONS - RR08
DEPARTMENT of PLANNING AND BUDGET (Transmittal Sheet) - DPBRR09

Copies of the Virginia Register Form, Style and Procedure Manual may also be obtained at the above address.

CALENDAR OF EVENTS

Symbols Key
† Indicates entries since last publication of the Virginia Register
♿ Location accessible to handicapped
☎ Telecommunications Device for Deaf (TDD)/Voice Designation

NOTICE

Only those meetings which are filed with the Registrar of Regulations by the filing deadline noted at the beginning of this publication are listed. Since some meetings are called on short notice, please be aware that this listing of meetings may be incomplete. Also, all meetings are subject to cancellation and the Virginia Register deadline may preclude a notice of such cancellation.

For additional information on open meetings and public hearings held by the Standing Committees of the Legislature during the interim, please call Legislative Information at (804) 786-6530.

VIRGINIA CODE COMMISSION

EXECUTIVE

DEPARTMENT FOR THE AGING

† **April 5, 1991 - 9 a.m.** – Open Meeting
State Capitol, House Room 1, Richmond, Virginia. ♿

A general business meeting of the Long-Term Care Council

Contact: Janet Lynch, Director, Office of Long-Term Care, Department for the Aging, 700 E. Franklin St., 10th Floor, Richmond, VA 23219-2327, telephone (804) 371-0552, SCATS 225-2271 or 225-2271/TDD ☎

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† **June 4, 1991 - 10 a.m.** – Public Hearing
Southwest Virginia Community College, Russell Hall Auditorium, Richlands, Virginia

† **June 5, 1991 - 10 a.m.** – Public Hearing
Melrose Towers, 3038 Melrose Avenue NW, Roanoke, Virginia

† **June 12, 1991 - 10 a.m.** – Public Hearing
Richard Bland College, 11301 Johnson Road, Petersburg, Virginia

† **June 13, 1991 - 10 a.m.** – Public Hearing
Norfolk State University, 2401 Corprew Avenue, Norfolk, Virginia

† **June 26, 1991 - 10 a.m.** – Public Hearing
The Massey Building, 4100 Chain Bridge Road, Fairfax, Virginia

A meeting to accept comments on the proposed State Plan for Aging Services developed pursuant to Title III of the Older Americans Act, as amended. Interested persons may submit data, views, and arguments, either orally or in writing, to the Department.

To receive a copy of the proposed State Plan and to obtain further information, write to or call the Department for the Aging.

See the General Notices section for additional information.

Contact: William H. McElveen, Deputy Commissioner, Virginia Department for the Aging, 700 East Franklin Street, 10th Floor, Richmond, Virginia 23219-2327, (804) 225-2271 or toll-free in Virginia 1-800-552-04464.

Long-Term Care Ombudsman Program Advisory Council

March 28, 1991 - 9:30 a.m. – Open Meeting
8007 Discovery Drive, Blair Builing, 2nd Floor, Conference Room A and B, Richmond, Virginia. ♿

Business will include review of goals and objective. Meeting attendees will include representatives of legislative groups concerned with aging issues.

Contact: Virginia Dize, State Obudsman, Department for the Aging, 700 E. Franklin St., 10th Floor, Richmond, VA 23219-2327, telephone (804) 225-3141, toll-free 1-800-552-3402 or 225-2271/TDD ☎

BOARD OF AGRICULTURE AND CONSUMER SERVICES

† **May 23, 1991 - 9 a.m.** – Open Meeting
Washington Building, Room 204, 1100 Bank Street, Richmond, Virginia. ♿

A regular meeting of the board to review issues relating to regulations and fiscal matters and to receive reports from the staff of the Department of Agriculture and Consumer Services. The board may consider other matters relating to its responsibilities.

The final item for the meeting will be opportunity for the public to make comment to the board, pursuant to § 2.1-343 of the Code of Virginia, with time reserved for this purpose not to exceed 30 minutes.

Contact: Roy E. Seward, Secretary to the Board, VDACS, Room 210, Washington Building, 1100 Bank St., Richmond, VA 23219, telephone (804) 786-3501 or (804) 371-6344/TDD ☎

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES (BOARD OF)

† **May 23, 1991 - 1 p.m.** – Public Hearing
Washington Building, Room 204, 1100 Bank Street, Richmond, Virginia.

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Agriculture and Consumer Services intends to consider amending regulations entitled: **VR 115-04-04. Rules and Regulations for the Enforcement of the Virginia Weights and Measures Law.**

At its meeting of February 20, 1991, the Board of Agriculture and Consumer Services decided to hold the record open to receive additional public comment on its proposed amendment to VR 115-04-04, Rules and Regulations for the Enforcement of the Virginia Weights and Measures Law, proposed in the Virginia Register on January 29, 1990 (Vol 6, Issue 9, pp. 1235 ff.). This proposed amendment would establish a method of sale and standards of fill, as determined by weight, for clams, mussels, oysters, and other mollusks.

The Board's decision to hold the record open came after it received a report from the Board's staff of a survey, requested by the Board, of the free-liquid content of oysters and other mollusks offered for retail sale in Virginia. The survey is entitled "Oyster Standards Survey – September 1, 1990 - January 31, 1991.

Statutory Authority: § 3.1-926 of the Code of Virginia.

Written comments may be submitted until April 29, 1991.

Contact: J. Alan Rogers, Bureau Chief, Weights and Measures Bureau, Washington Bldg., Room 402, 1100 Bank St., P.O. Box 1163, Richmond, VA 23209, telephone (804) 786-2476.

Pesticide Control Board

May 10, 1991 - 10:30 a.m. – Public Hearing
Sheraton Airport Inn, Salons A and B of Ballroom, 4700 South Laburnum Avenue, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Pesticide Control Board intends to amend regulations entitled: **VR 115-04-03. Rules and Regulations for Enforcement of the Virginia Pesticide Law.** The 1989 Virginia Pesticide Control Act authorizes the Pesticide Control Board to adopt regulations to accomplish the Act's purpose. To this end, the board has proposed VR 015-04-23, Regulations Governing Pesticide Applicator Certification Under Authority of Virginia Pesticide Control Act. Parts of this proposed regulation are intended to supersede § 21, "Categories for commercial applicators"; § 22, Standards of certification of commercial applicators"; § 24, Standards for certification of private applicators"; and § 25, "Standards for application of pesticides classified for restricted use by noncertified applicators" of VR 115-04-03, Rules and Regulations for Enforcement of the Virginia Pesticide Law. The provisions of VR 115-04-03 are to remain in effect, according to the Act, "until repealed by the Pesticide Control Board." The purpose of this regulatory action is to propose the repeal of these four identified sections of VR 115-04-03.

Statutory Authority: § 3.1-249.28 of the Code of Virginia.

Written comments may be submitted until 5 p.m., April 30, 1991.

Contact: C. Kermit Spruill, Jr., Director, Division of Product and Industry Regulation, Department of Agriculture and Consumer Services, P.O. Box 1163, Room 403, 1100 Bank St., Richmond, VA 23209, telephone (804) 786-3523.

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May 10, 1991 - 10:30 a.m. – Public Hearing
Sheraton Airport Inn, Salons A and B of Ballroom, 4700 South Laburnum Avenue, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Pesticide Control Board intends to adopt regulations entitled: **VR 115-04-23. Regulations Governing Pesticide Applicator Certification Under Authority of Virginia Pesticide Control Act.**

Regulations Governing Pesticide Applicator Certification under Authority of Virginia Pesticide Control Act set standards of certification for persons specified by statute who use or supervise the use of pesticides in Virginia (including but not limited to farmers using restricted-use pesticides on their own land and persons who apply pesticides commercially, but excluding persons who use nonrestricted-use pesticides in and around their own homes). This regulation will help to assure that these persons subject to the regulation are adequately trained and competent to use pesticides, an important element in any effort to ensure that pesticides are used in a manner consistent with public health, public safety, and the well-being of the environment.

The proposed regulation includes, among other things, standards for training and testing of registered technicians, a classification of pesticide applicator newly created under the Pesticide Control Act, and for private applicators and commercial applicators, classifications of pesticide applicators that exist at present under VR 115-04-03, Rules and Regulations for Enforcement of the Virginia Pesticide Law.

The proposed regulation sets standards of financial responsibility for those who apply pesticides commercially who are not subject to the present business-license regulation. (Licensed pesticide businesses are required to meet certain measures of financial responsibility under a regulation already in effect.)

The proposed regulation requires those subject to its requirements to report pesticide spills.

In part the proposed regulation is intended to supersede four related but different sections of VR 115-04-03.

Statutory Authority: § 3.1-249.30 of the Code of Virginia.

Written comments may be submitted until 5 p.m., April 30, 1991.

Contact: C. Kermit Spruill, Jr., Director, Division of Product and Industry Regulation, Department of Agriculture and Consumer Services, P.O. Box 1163, Room 403, 1100 Bank St., Richmond, VA 23209, telephone (804) 786-3523.

STATE AIR POLLUTION CONTROL BOARD

† **April 24, 1991 - 10 a.m.** – Public Hearing
State Capitol Building, House Room 1, Richmond, Virginia.

A meeting to consider the latest edition of referenced technical and scientific documents and to incorporate newly promulgated federal New Source Performance Standards and National Emission Standards for Hazardous Air Pollutants.

Input will be received on the development of the proposed regulation.

Contact: Nancy S. Saylor, Policy Analyst, Division of Program Development, Department of Air Pollution Control, P.O. Box 10089, Richmond, VA 23240, telephone (804) 786-1249.

DEPARTMENT OF AIR POLLUTION CONTROL

March 26, 1991 - 7:15 p.m. – Public Hearing
Handley Public Library Auditorium, 100 West Piccadilly Street, Winchester, Virginia.

A public hearing to consider a permit application from Amoco Foam Products to modify and operate its expanded polystyrene products plant in Winchester, Virginia.

Contact: William N. Millward, Department of Air Pollution Control Region VII, 6225 Brandon Avenue, Springfield, VA, telephone (703) 644-0311.

ASAP POLICY BOARD - CENTRAL VIRGINIA

† **March 25, 1991 - 7:15 p.m.** – Open Meeting
Cedar Street, 3009 Old Forest Road, Lynchburg, Virginia.

Spring policy board meeting regarding program activities for the previous quarter and future operations.

Contact: L.T. Townes, P.O. Box 4345, Lynchburg, VA 24502, telephone (804) 528-4073.

ASAP POLICY BOARD - MOUNT ROGERS

† **April 3, 1991 - 1 p.m.** – Open Meeting
Oby's Restaurant, Marion, Virginia. ♿ (Interpreter for the deaf provided upon request)

A meeting of the Mount Rogers ASAP Board of Directors. The board meets every other month to conduct business. The order of business at all regular meetings shall be as follows; (i) call to order; (ii) roll call; (iii) approval of minutes; (iv) unfinished business; (v) new business; and (vi) adjournment.

Contact: J. L. Reedy, Director, Mount Rogers ASAP, 1102 North Main St., Marion, VA 23454, telephone (703) 783-7771.

BOARD OF AUDIOLOGY AND SPEECH PATHOLOGY

† **May 23, 1991 - 10 a.m.** – Open Meeting
1601 Rolling Hills Drive, Richmond, Virginia. ♿

A regularly scheduled board meeting.

Contact: Meredyth P. Partridge, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-9907.

BOARD FOR BARBERS

† **April 8, 1991 - 9 a.m.** – Open Meeting
Department of Commerce, 5th Floor, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting to (i) review applications; (ii) review correspondence; (iii) review enforcement cases; (iv) conduct regulatory review; and (v) consider routine

board business.

Contact: Roberta L. Banning, Assistant Director, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590.

VIRGINIA CATTLE INDUSTRY BOARD

† **April 15, 1991 - 11 a.m.** – Open Meeting
† **April 16, 1991 - 8:15 a.m.** – Open Meeting
Holiday Inn Koger Center, 1021 Koger Center Boulevard, Richmond, Virginia. ♿

The Virginia Cattle Industry Board will meet to determine the budget for 1991-92. The board will determine which projects in the areas of research, consumer education, and industry information will be funded.

Contact: Reggie Reynolds, Executive Director, P.O. Box 176, Daleville, VA 24083, telephone (703) 992-1992.

CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

April 4, 1991 - 10 a.m. – Open Meeting
Virginia War Memorial Auditorium, 621 South Belvidere Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to conduct general business and review local Chesapeake Bay Preservation Act programs. Tentative agenda will be available at the Chesapeake Bay Local Assistance Department by March 29, 1991.

Contact: Receptionist, 805 East Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or 1-800-243-7229/TDD ☎

VIRGINIA COUNCIL ON CHILD DAY CARE AND EARLY CHILDHOOD PROGRAMS

March 28, 1991 - 2 p.m. – Public Hearing
March 28, 1991 - 7 p.m. – Public Hearing
Norfolk City Council Chambers, City Hall Building, 810 Union Street, Norfolk, Virginia.

April 4, 1991 - 10 a.m. – Public Hearing
Virginia Housing Development Authority, 1st Floor Conference Room, 602 Belvidere Street, Richmond, Virginia.

April 10, 1991 - 2 p.m. – Public Hearing
April 10, 1991 - 7 p.m. – Public Hearing
Alexandria City Council Chambers, Alexandria City Hall, 301 King Street, Alexandria, Virginia.

The Council is the lead agency in Virginia for administration of a new federal grant, the Child Care and Development Block Grant. The Council is holding public hearings to solicit comments on child care needs in the state. Interested persons or groups are encouraged to attend. Individuals who want to testify should contact the Council's Richmond Office (1-804-371-8603) to reserve a time slot.

Contact: Linda Sawyers, Director, Virginia Council on Child Day Care and Early Childhood Programs, Suite 1116, Washington Bldg., 1100 Bank St., Richmond, VA 23219, telephone (804) 371-8603.

BOARD OF COMMERCE

† **April 24, 1991 - 9 a.m.** – Public Hearing
Department of Commerce, 3600 West Broad Street, 3rd Floor Multipurpose Room, Richmond, Virginia. ♿

A public hearing in connection with the administration's "Project Streamline" on the need for the Commonwealth to continue a regulatory and voluntary certification program for landscape architects.

† **April 24, 1991 - 9 a.m.** – Public Hearing
Department of Commerce, 3600 West Broad Street, 5th Floor, Conference Room 1, Richmond, Virginia. ♿

A public hearing in connection with the administration's "Project Streamline" on the need for the Commonwealth to continue a regulatory and voluntary certification program for interior designers.

† **April 24, 1991 - 1 p.m.** – Public Hearing
Department of Commerce, 3600 West Broad Street, 5th Floor, Conference Room 1, Richmond, Virginia. ♿

A public hearing in connection with the administration's "Project Streamline" on the need for the Commonwealth to continue a regulatory program within the Real Estate Board for rental agents.

† **April 24, 1991 - 1 p.m.** – Public Hearing
Department of Commerce, 3600 West Broad Street, 3rd Floor Multipurpose Room, Richmond, Virginia. ♿

A public hearing in connection with the administration's "Project Streamline" on the need for the Commonwealth to continue a regulatory and licensing program for polygraph (lie detector) examiners.

† **April 24, 1991 - 3 p.m.** – Public Hearing
Department of Commerce, 3600 West Broad Street, 5th Floor, Conference Room 1, Richmond, Virginia. ♿

A public hearing in connection with the administration's "Project Streamline" on the need for the Commonwealth to continue a regulatory and voluntary certification program for soil scientists.

† **April 24, 1991 - 3 p.m.** – Public Hearing
Department of Commerce, 3600 West Broad Street, 3rd Floor Multipurpose Room, Richmond, Virginia. ♿

A public hearing in connection with the administration's "Project Streamline" on the need for the Commonwealth to continue a regulatory and voluntary certification program for geologists.

† **April 25, 1991 - 2 p.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, 5th Floor, Conference Room 1, Richmond, Virginia. ♿

A regular meeting of the board to discuss the progress and results of studies directed by the administration's "Project Streamline" (studies of the department's regulatory programs).

Contact: Alvin D. Whitley, Staff Assistant to Board, Department of Commerce, 3600 West Broad St., Richmond, VA 23230, telephone (804) 367-8564 or SCATS 367-8519.

COMPENSATION BOARD

April 25, 1991 - 5 p.m. – Open Meeting
Ninth Street Office Building, 202 North Ninth Street, 9th Floor, Room 913/913A, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A routine meeting to conduct business of the board.

Contact: Bruce W. Haynes, Executive Secretary, P.O. Box 3-F, Richmond, VA 23206-0686, telephone (804) 786-3886 or (804) 786-3886/TDD ☎

DEPARTMENT OF CONSERVATION AND RECREATION

Guest Scenic River Advisory Board

April 18, 1991 - 7 p.m. – Open Meeting
Coeburn Town Hall, 403 Second Street, Coeburn, Virginia.

A meeting to review river issues and programs.

Contact: Richard Gibbons, Environmental Programs Manager, Department of Conservation and Recreation, Division of Planning and Recreation Resources, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-4132 or 786-2121/TDD ☎

BOARD FOR CONTRACTORS

March 28, 1991 - 10 a.m. – Open Meeting
Municipal Building, Conference Room, 215 Church Avenue, 4th Floor, Roanoke, Virginia.

The board will meet to conduct a formal hearing: File Number 89-00558, Board for Contractors v. John T. Chitwood, III, t/a J T's Remodeling .

Contact: Gayle Eubank, Hearings Coordinator, Department of Commerce, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-8524.

Recovery Fund Committee

March 26, 1991 - 9 a.m. – Open Meeting
3600 West Broad Street, Richmond, Virginia. ♿

A meeting to consider claims filed against the Virginia Contractor Transaction Recovery Fund. This meeting is open to the public; however, a portion of the discussion may be conducted in Executive Session.

Contact: Vickie Brock, Recovery Fund Administrator, 3600 W. Broad St., Richmond, VA 23219, telephone (804) 367-2394.

BOARD OF CORRECTIONS

April 17, 1991 - 10 a.m. – Open Meeting
6900 Atmore Drive, Board of Corrections Board Room, Richmond, Virginia. ♿

A regular monthly meeting to consider such matters as may be presented.

Contact: Ms. Vivian Toler, Secretary to the Board, 6900 Atmore Dr., Richmond, VA 23225, telephone (804) 674-3235.

BOARD FOR COSMETOLOGY

† **March 25, 1991 - 9 a.m.** – Open Meeting
† **March 26, 1991 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, 5th Floor, Richmond, Virginia. ♿

A meeting to (i) review applications; (ii) review correspondence; (iii) review enforcement cases; (iv) conduct regulatory review: (v) review written nail, cosmetology and instructor examinations; and (iv) consider routine board business.

Contact: Roberta L. Banning, Assistant Director, 3600 West Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8590.

COURT APPOINTED SPECIAL ADVOCATE AND CHILDREN'S JUSTICE ACT ADVISORY COMMITTEE

† **March 28, 1991 - 10 a.m.** – Open Meeting
Virginia Housing Development Authority Building, 601 South Belvidere Street, Richmond, Virginia. ♿

A meeting to discuss business of the committee.

Contact: Paula J. Scott, Staff Executive, Department of Criminal Justice Services, 805 E. Broad St., Richmond, VA 23219, telephone (804) 786-4000.

CRIMINAL JUSTICE SERVICES BOARD

† **April 3, 1991 - 11 a.m.** – Open Meeting
James Monroe Building, 101 North 14th Street, Conference Room B, Richmond, Virginia.

A meeting to consider matters related to the board's responsibilities for criminal justice training and improvement of the criminal justice system. Public comment will be heard before adjournment of the meeting.

Committee on Training

† **April 3, 1991 - 9 a.m.** – Open Meeting
James Monroe Building, 101 North 14th Street, Conference Room B, Richmond, Virginia.

A meeting to discuss matters related to training for criminal justice personnel.

Contact: Paula J. Scott, Staff Executive, Department of Criminal Justice Services, 805 E. Broad St., Richmond, VA 23219, telephone (804) 786-4000.

BOARD OF DENTISTRY

April 24, 1991 - 2 p.m. – Open Meeting
April 25, 1991 - 8:30 a.m. – Open Meeting
April 26, 1991 - 8:30 a.m. – Open Meeting
April 27, 1991 - 1 p.m. – Open Meeting
1601 Rolling Hills Drive, Conference Room 1, Richmond, Virginia.

Committee Meetings on Wednesday

Regulatory, Executive and Advertising

Committee Reports on Thurs, Fri and Sat
Regulatory Committee
Advertising Committee
Executive Committee
Legislative Committee
Budget Committee
Exam Committee
Dental Hygiene Endorsement Committee

Regular Board Business on Thurs, Fri and Sat

Formal Hearings on Thurs, Fri and Sat

This is a public meeting and the public is invited to observe. Public testimony will be received by the board at this meeting.

April 27, 1991 - 10 a.m. – Public Hearing
Surry Building, 1601 Rolling Hills Drive, Conference Room 1, Richmond, Virginia.

The board will conduct its Biennial Informational Public Hearing to receive comments on the current regulations and topics.

Contact: Nancy Taylor Feldman, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229-5005, telephone (804) 662-9906.

BOARD OF EDUCATION

March 28, 1991 - 8 a.m. – Open Meeting
March 29, 1991 - 9 a.m. – Open Meeting
James Monroe Building, Conference Rooms D and E, 101 North Fourteenth Street, Richmond, Virginia. (Interpreter for deaf provided if requested)

A joint meeting of the Board of Education and the Board of Vocational Education. Business will be conducted according to items listed on the agenda. The agenda is available upon request. Public comment will not be received at the meeting.

Contact: Margaret Roberts, Executive Director Board of Education, State Department of Education, P.O. Box 6-Q, Richmond, VA 23216, telephone (804) 225-2540.

LOCAL EMERGENCY PLANNING COMMITTEE - ARLINGTON COUNTY/CITY OF FALLS CHURCH

April 25, 1991 - 7:30 p.m. – Open Meeting
Fire State Number 1, 500 South Glebe Road, Arlington, Virginia. (Interpreter for deaf provided upon request)

Local Emergency Planning committee meeting to meet requirements of SARA.

Contact: Thomas M. Hawkins, Jr., Chairman, 2100 Clarendon Blvd., Suite 400, Fire Department Administration, Arlington, VA 22201, telephone (703) 358-3365 or (703) 558-2096/TDD ☎

LOCAL EMERGENCY PLANNING COMMITTEE - CHESTERFIELD COUNTY

April 4, 1991 - 5:30 p.m. – Open Meeting
May 2, 1991 - 5:30 p.m. – Open Meeting
† **June 6, 1991 - 5:30 p.m.** – Open Meeting
Chesterfield County Administration Building, Room 502, 10,001 Ironbridge Road, Chesterfield, Virginia.

A meeting to meet requirements of Superfund Amendment and Reauthorization Act of 1986.

Contact: Lynda G. Furr, Assistant Emergency Services

Coordinator, Chesterfield Fire Department, P.O. Box 40, Chesterfield, VA 23832, telephone (804) 748-1236.

LOCAL EMERGENCY PLANNING COMMITTEE - GLOUCESTER COUNTY

† **April 24, 1991 - 6:30 p.m.** – Open Meeting
Gloucester Administration Office Building, Gloucester, Virginia. ♿

The spring quarterly meeting of the Gloucester LEPC will address election of officers and review of a draft for the Hazmat Plan Update.

Contact: Georgette N. Hurley, Assistant County Administrator, P.O. Box 329, Gloucester, VA 23061, telephone (703) 693-4042.

VIRGINIA EMERGENCY RESPONSE COUNCIL

April 22, 1991 - 10 a.m. – Open Meeting
Monroe Building, Conference Room B, 101 North 14th Street, Richmond, Virginia. ♿

This meeting will provide the VERC with an update of issues concerning local governments/and Local Emergency Planning Committees (LEPCs) regarding emergency planning and preparedness; and this meeting will recommend additional outreach to local governments and to LEPCs to further their SARA Title III activities to Virginia communities.

Contact: Cathy L. Harris, Environmental Program Manager, Virginia Department of Waste Management, Monroe Building, 14th Floor, 101 N. 14th St., Richmond, VA 23219, telephone (804) 225-2513, 225-2613, toll-free 1-800-552-2075 or (804) 371-8737/TDD ☎

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

April 10, 1991 - 9 a.m. – Open Meeting
April 19, 1991 - 9 a.m. – Open Meeting
1601 Rolling Hills Drive, Conference Room 1, Richmond, Virginia. ♿

A regularly scheduled board meeting. Public comment will be received during last 30 minutes of meeting.

† **May 6, 1991 - 9 a.m.** – Open Meeting
1601 Rolling Hills Drive, Conference Rooms 1 and 3, Richmond, Virginia. ♿

Funeral directors and embalmers examinations and board meeting.

Contact: Meredyth P. Partridge, Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229-5005, telephone (804) 662-9907.

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April 15, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Funeral Directors and Embalmers intends to adopt regulations entitled: **VR 320-01-04. Curriculum for Resident Trainee Program.** The regulation is designed to provide consistency and accountability in the funeral trainee program.

Statutory Authority: § 54.1-2803 of the Code of Virginia.

Written comments may be submitted until April 15, 1991.

Contact: Meredyth Partridge, Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229, telephone (804) 662-9941 or SCATS 8-662-7390.

BOARD FOR GEOLOGY

† **March 25, 1991 - 10 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Conference Room 3, Richmond, Virginia. ♿

A general board meeting to consider position paper for Project Streamline.

Contact: Nelle P. Hotchkiss, Assistant Director, Department of Commerce, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595.

HAZARDOUS MATERIALS TRAINING COMMITTEE

† **March 26, 1991 - 10 a.m.** – Open Meeting
Division of Emergency Medical Services, 1538 East Parham Road, Richmond, Virginia.

The purpose of this meeting will be to discuss curriculum course development and to review existing hazardous materials courses.

Contact: N. Paige Bishop, Henrico County Fire Training Bureau, 10771 Old Washington Highway, Glen Allen, VA 23060, telephone (804) 264-2423.

DEPARTMENT OF HEALTH (STATE BOARD OF)

† **April 11, 1991 - 10 a.m.** – Open Meeting
Main Street Station, 1500 East Main Street, Community Room, Richmond, Virginia. ♿

A meeting to discuss the proposed plan for HIV Care Grant moneys under Title II of the Ryan White Care Comprehensive AIDS Resource Emergency Act of 1990.

Contact: Kathryn A. Hafford, Coordinator of Education, Information and Training, Department of Health, Bureau of SID/AIDS, Room 112, P.O. Box 2448, Richmond, VA 23219, telephone (804) 225-4844.

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April 25, 1991 - 9 a.m. – Public Hearing
James Monroe Building, Conference Room B, 101 North 14th Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Health intends to adopt regulations entitled: **VR 355-40-04. Regulations Governing the Virginia Medical Scholarship Program.** The proposed regulations set forth eligibility criteria award process, terms, conditions and circumstances under which Virginia medical scholarship will be awarded.

Statutory Authority: § 32.1-122.6 B of the Code of Virginia.

Written comments may be submitted until April 26, 1991.

Contact: Raymond O. Perry, Director, Virginia Department of Health, Office of Planning and Regulatory Services, 1500 E. Main St., Suite 105, Richmond, VA 23219, telephone (804) 786-6970.

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April 25, 1991 - 1 p.m. – Public Hearing
James Monroe Building, Conference Room B, 101 North 14th Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Health intends to adopt regulations entitled: **VR 355-40-05. Rules and Regulations for the Identification of Medically Underserved Areas in Virginia.** The regulations set forth the criteria for identification of areas within the Commonwealth that are in need of additional primary health care services and for the designation of areas so identified as medically underserved areas.

Statutory Authority: § 32.1-122.5 of the Code of Virginia.

Written comments may be submitted until April 26, 1991.

Contact: Raymond O. Perry, Director, Virginia Department of Health, Office of Planning and Regulatory Services, 1500 E. Main St., Suite 105, Richmond, VA 23219, telephone (804) 786-6970.

DEPARTMENT OF HEALTH PROFESSIONS

Administration and Budget Committee

April 17, 1991 - 8:30 a.m. – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room 2, Richmond, Virginia.

A meeting to consider preliminary cost center budgets requests for the 92-94 biennium.

Contact: Richard Morrison, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23219, telephone (804) 662-9904.

Regulatory Research Committee

April 15, 1991 - 4 p.m. – Public Hearing
Department of Health Professions, 1601 Rolling Hills Drive, Room 1, Richmond, Virginia. (Interpreter for deaf provided upon request)

An informational public hearing (See General Notices section.)

Contact: Richard Morrison, Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23219, telephone (804) 662-9904.

VIRGINIA HEALTH SERVICES COST REVIEW COUNCIL

March 26, 1991 - 9:30 a.m. – Open Meeting
Department of Rehabilitative Services, 4901 Fitzhugh Avenue, Richmond, Virginia.

† **April 23, 1991 - 9:30 a.m.** – Open Meeting
Blue Cross/Blue Shield of Virginia, The Virginia Room, 2015 Staples Mill Road, Richmond, Virginia.

A monthly meeting to address financial, policy or technical matters which may have arisen since the last meeting.

Contact: G. Edward Dalton, Deputy Director, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371.

STATE COUNCIL OF HIGHER EDUCATION

† **April 3, 1991 - 9 a.m.** – Open Meeting
Mary Washington College, Fredricksburg, Virginia.

A general business meeting.

Contact: Barry Dorsey, Deputy Director, Monroe Building, 9th Floor, 101 N. 14th St., Richmond, VA 23219, telephone (804) 225-2629.

BOARD OF HISTORIC RESOURCES

† **April 17, 1991 - 10:30 a.m.** – Open Meeting
General Assembly Building, Senate Room A, Richmond, Virginia. (Interpreter for the deaf provided if requested)

A general business meeting.

Contact: Margaret Peters, 221 Governor St., Richmond, VA 23219, telephone (804) 786-3143 or (804) 786-1934/TDD ☎

DEPARTMENT OF HISTORIC RESOURCES

State Review Board

† **April 16, 1991 - 10 a.m.** – Open Meeting
General Assembly Building, Senate Room A, Richmond, Virginia. ♿ (Interpreter for the deaf provided if requested)

A meeting to consider the nomination of the following properties to the Virginia Landmarks Register and the National Register of Historic Places:

Arrowhead, Albemarle County (DHR 02-195)

Batte, Alexander Watson, House, Greensville County (DHR 40-02)

Chilhowie Methodist Church, Chilhowie, Smyth County (DHR 86-14)

Dinwiddie County Pullman Car, Chesterfield County

Hare Forest, Orange County (DHR 68-124)

Kentland Farm Historic and Archeological District, Montgomery County (DHR 60-202)

Patrick Henry Hotel, City of Roanoke (DHR 128-235)

Seven Islands Farm, Buckingham County (DHR 14-23)

Sugar Loaf Farm, Augusta County

Wavertree Hall Farm, Albermarle County

Contact: Margaret Peters, 221 Governor St., Richmond, VA 23219, telephone (804) 786-3143 or (804) 786-1934/TDD ☎

HOPEWELL INDUSTRIAL SAFETY COUNCIL

† **April 2, 1991 - 9 a.m.** – Open Meeting
Hopewell Community Center, Second and City Point Road, Hopewell, Virginia. ♿ (Interpreter for deaf provided upon request)

Local Emergency Preparedness Committee Meeting on Emergency Preparedness as required by SARA Title III.

Contact: Robert Brown, Emergency Service Coordinator, 300 N. Main St., Hopewell, VA 23860, telephone (804) 541-2298.

DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT

April 11, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Housing and Community Development intends to amend regulations entitled: **VR 394-01-105. Share Expansion Grant/Loan Program.** The SHARE Expansion Grant/Loan Program provides grants and loans for the expansion or creation of emergency shelters, transitional facilities and single room occupancy units.

Statutory Authority: § 36-141 et seq. Code of Virginia.

Written comments may be submitted until April 11, 1991.

Contact: Irene Clouse DHCD, Program Administrator, 205 N. 4th St., Richmond, VA 23219, telephone (804) 371-8734.

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

April 3, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Housing Development Authority intends to amend regulations entitled: **VR 400-02-0011. Rules and Regulations For Allocation of Low-Income Housing Tax Credits.**

Statutory Authority: § 36-55.30:3 of the Code of Virginia.

Written comments may be submitted until April 3, 1991.

Contact: J. Judson McKellar, Jr., General Council, Virginia Housing Development Authority, 601 S. Belvidere St., Richmond, VA 23220, telephone (804) 782-1986.

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April 5, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Housing Development Authority intends to adopt regulations entitled: **VR 400-02-0017. Rules and Regulations for HUD-Insured Home Equity Conversion Mortgage Loans to Elderly Persons of Low and Moderate Income.**

Statutory Authority: § 36-55.30:3 of the Code of Virginia.

Written comments may be submitted until April 5, 1991.

Contact: J. Judson McKellar, Jr., General Council, Virginia

Housing Development Authority, 601 S. Belvidere St., Richmond, VA 23220, telephone (804) 782-1986.

COUNCIL ON INDIANS

March 27, 1991 - 2 p.m. – Open Meeting
Koger Executive Complex/Nelson Building, Department of Social Services, 2nd Floor Training Conference Room, 1503 Santa Rosa Road, Richmond, Virginia. ♿

A regular meeting of the Virginia Council on Indians to conduct general business and to receive reports from the Council Standing Committees.

Contact: Mary Zoller, Secretary Manager, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9285 or toll-free 1-800-552-7096.

VIRGINIA INTERAGENCY COORDINATING COUNCIL

† **May 8, 1991 - 9 a.m.** – Open Meeting
James Monroe Building, 101 North 14th Street, Conference Rooms D and E, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The Virginia Interagency Coordinating Council (VICC) according to PL 101-476, Part H, early intervention program for disabled infants and toddlers and their families, is meeting to advise and assist the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services as lead agency, to develop and implement a statewide interagency early intervention program.

Contact: Michael Fehl, Director, Mental Retardation Children/Youth Services, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3710.

INTERDEPARTMENTAL REGULATION OF RESIDENTIAL FACILITIES FOR CHILDREN

Coordinating Committee

April 19, 1991 - 8:30 a.m. – Open Meeting
Office of the Coordinator, Interdepartmental Regulation, Suite 208, 1603 Santa Rosa Road, Tyler Building, Richmond, Virginia. ♿

Regularly scheduled meetings to consider such administrative and policy issues as may be presented to the committee. A period for public comment is provided at each meeting.

Contact: John J. Allen, Jr., Coordinator, Interdepartmental Regulation, Office of the Coordinator, 8007 Discovery Dr., Richmond, VA 23229-8699, telephone (804) 662-7124.

JOINT BOARD LIAISON COMMITTEE

† **April 19, 1991 - 10 a.m.** – Open Meeting
Department of Education, Monroe Building, 101 North 14th Street, Richmond, Virginia. ♿

Quarterly meeting of the Joint Board Liaison Committee comprised of representatives of the Boards of Corrections, Education, Health, Medical Assistance Services; Mental Health, Mental Retardation and Substance Abuse Services; Rehabilitative Services; Social Services; Youth and Family Services; and the Advisory Board for the Department for Children. Agenda items include topics of common interest and the development of joint policies relative to clients who are mutually served.

Contact: Jane Helfrich, Administrative Staff, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3921.

DEPARTMENT OF LABOR AND INDUSTRY

Virginia Apprenticeship Council

March 28, 1991 - 1 p.m. – Open Meeting
State Capitol Building, House Room 4, Richmond, Virginia. ♿

An open meeting for the purpose of discussing the relationship between Virginia's Apprenticeship Program and the Federal Davis-Bacon Act.

Contact: Dr. Thomas E. Butler, Assistant Commissioner, Training and Public Services, Department of Labor and Industry, P.O. Box 12064, Richmond, VA 23241, telephone (804) 786-4300.

Safety and Health Codes Board

† **April 16, 1991 - 10 a.m.** – Open Meeting
General Assembly Building, House Room C, 910 Capitol Street, Richmond, Virginia. ♿

The board will meet to consider (i) technical corrections to amendment to the General Industry Standard for Control of Hazardous Energy Sources (Lockout/Tagout) - § 1910.147 - Final Rule; (ii) Safety Standards for Stairways and Ladders used in the Construction Industry - Final Rule; (iii) technical corrections to Safety Standards for Stairways and Ladders Used in the Construction Industry - Final Rule; and (iv) revision of the Boiler and Pressure Vessel Safety Rules and Regulations - Final Rule.

Contact: John Crisanti, Director, Policy Enforcement Office, Department of Labor and Industry, P.O. Box 12064, Richmond, VA 23241, telephone (804) 786-2384.

COMMISSION ON LOCAL GOVERNMENT

April 29, 1991 - 11 a.m. – Open Meeting
Alleghany County, Clifton Forge Area - Site to be determined.

Oral presentations regarding the proposed Alleghany County - City of Clifton Forge Consolidation.

Persons desiring to participate in the commission's oral presentations and requiring special accommodations or interpreter services should contact the Commission's office by April 22, 1991.

April 30, 1991 - 9 a.m. – Open Meeting
Alleghany County, Clifton Forge Area - Site to be determined.

Oral presentations regarding the proposed Alleghany County - City of Clifton Forge Consolidation.

Persons desiring to participate in the commission's oral presentations and requiring special accommodations or interpreter services should contact the Commission's office by April 23, 1991.

April 30, 1991 - 7 p.m. – Public Hearing
Alleghany County, Clifton Forge Area - Site to be determined.

Public hearing regarding the proposed Alleghany County - City of Clifton Forge Consolidation.

Persons desiring to participate in the commission's oral presentations and requiring special accommodations or interpreter services should contact the Commission's office by April 23, 1991.

May 1, 1991 - 9 a.m. – Open Meeting
Alleghany County, Clifton Forge Area - Site to be determined.

Oral presentations regarding the proposed Alleghany County - City of Clifton Forge Consolidation.

Persons desiring to participate in the commission's oral presentations and requiring special accommodations or interpreter services should contact the Commission's office by April 24, 1991.

Contact: Barbara W. Bingham, Administrative Assistant, 702 Eighth Street Office Bldg., Richmond, VA 23219, telephone (804) 786-6508 or (804) 786-1860/TDD ☎

LONGWOOD COLLEGE

Academic/Student Affairs Committee

† **April 3, 1991 - 1:30 p.m.** – Open Meeting
Longwood College, Ruffner Building, Board Room, Farmville, Virginia. ♿

A meeting to conduct routine business of the committee.

Board of Visitors

April 28, 1991 - 7 p.m. – Open Meeting
April 29, 1991 - 9 a.m. – Open Meeting
Longwood College, Ruffner Building, Virginia Room, Farmville, Virginia. ♿

A meeting to conduct routine business.

Contact: William F. Dorrill, President, Longwood College, Farmville, VA 23901, telephone (804) 395-2001.

STATE LOTTERY BOARD

NOTE: CHANGE IN MEETING DATE AND TIME
March 25, 1991 - 11 a.m. – Open Meeting
State Lottery Department, 2201 West Broad Street, Conference Room, Richmond, Virginia. ♿

A regular monthly meeting of the board. Business will be conducted according to items listed on agenda which has not yet been determined. Two periods for public comment are scheduled.

Contact: Barbara L. Robertson, Lottery Staff Officer, State Lottery Department, 2201 W. Broad St., Richmond, VA 23220, telephone (804) 367-9433.

MARINE RESOURCES COMMISSION

March 26, 1991 - 9:30 a.m. – Open Meeting
2600 Washington Avenue, 4th Floor, Room 403, Newport News, Virginia. ♿ (Interpreter for deaf provided if requested)

The Commission will hear and decide marine environmental matters at 9:30 a.m.: permit applications for projects in wetlands, bottom lands, coastal primary sand dunes and beaches; appeals of local wetland board decisions; policy and regulatory issues.

The Commission will hear and decide fishery management items at approximately 2 p.m.: regulatory proposals; fishery management plans; fisher conservation issues; licensing; shell-fish leasing.

Meetings are open to the public. Testimony is taken under oath from parties addressing agenda items on permits, licensing. Public comments are taken on resource matters, regulatory issues, and items scheduled for public hearing.

The Commission is empowered to promulgate regulations in the areas of marine environmental

management and marine fishery management.

Contact: Cathy W. Everett, Secretary to the Commission, P.O. Box 756, Room 1006, Newport News, VA 23607, telephone (804) 247-8088.

BOARD OF MEDICAL ASSISTANCE SERVICES

March 27, 1991 - 1 p.m. – Open Meeting
† **April 15, 1991 - 1 p.m.** – Open Meeting
Board Room, Suite 1300, 600 East Broad Street, Richmond, Virginia. &

An open meeting to discuss Medical Assistance Services and issues pertinent to the board.

Contact: Patricia A. Sykes, Policy Analyst, Suite 1300, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-7958, toll-free 1-800-552-8627 or 1-800-343-0634/TDD ☎

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

† **April 4, 1991 - 1 p.m.** – Open Meeting
600 East Broad Street, Suite 1300, Richmond, Virginia. &

Medicaid New Drug Review Committee meeting to review new chemical entities for recommendations to the Board of Medical Assistance Services.

Contact: David B. Shepherd, R.Ph., Pharmacy Supervisor, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-3820 or toll-free 1-800-552-8627.

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April 26, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to adopt regulations entitled: **VR 460-03-4.1921. Methods and Standards for Other Types of Services: Obstetric and Pediatric Maximum Payments.** The purpose of this proposal is to promulgate permanent regulations regarding specific obstetric and pediatric maximum payment amounts by DMAS which became effective July 1, 1990.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until April 26, 1991, to Mack Brankley, Director, Division of Client Services, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, Virginia.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

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April 26, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **VR 460-04-8.5. Home and Community Based Services for Technology Dependent Individuals.** The purpose of this proposal is to promulgate permanent regulations regarding Medicaid services for technology-assisted individuals, to supersede the temporary emergency regulation which became effective on June 22, 1990.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until April 26, 1991, to Chris Pruett, Analyst, Division of Quality Care Assurance, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, Virginia.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

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May 10, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance intends to amend regulations entitled: **VR 460-02-3.1100. Amount, Duration and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy; VR 460-02-3.1200. Amount, Duration and Scope of Services Provided Medically Needy Group(s): All; VR 460-03-3.1100. Amount, Duration and Scope of Services; VR 460-02-3.1300. Standards Established and Methods to Assure High Quality of Care; and VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates - Other Types of Care; and to adopt new regulations entitled VR 460-04-8.8. Regulations for Hospice Services.** The purpose of this proposal is to promulgate permanent regulations providing for the coverage of hospice services.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until May 10, 1991, 5 p.m., to Mary Chiles, R. N., Manager, Division of Quality Care Assurance, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, Virginia.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

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† **May 24, 1991** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to adopt and amend regulations entitled: **State Plan for Medical Assistance Relating to Long-Stay Acute Care Hospitals. VR 460-02-3.1300, Standards Established and Methods Used to Assure High Quality Care and VR 460-04-8.10, Long-Stay Acute Care Hospitals.** The purpose of the proposed regulation is to regulate the provision of long-stay acute care hospital services.

STATEMENT

Basis and authority: Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:9, for this agency's promulgation of proposed regulations subject to the Department of Planning and Budget's and Governor's reviews. Subsequent to the emergency adoption action and filing with the Registrar of Regulations, the Code requires this agency to initiate the public notice and comment process as contained in Article 2 of the APA.

The Code of Federal Regulations, Title 42, Part 456, grants states the authority to perform admission review, utilization review, and certification for continued stay in long stay acute care hospitals.

The Board of Medical Assistance Services (BMAS), in response to the Administration's directive to identify potential cost savings initiatives, directed DMAS to implement the policy described in this proposed regulation.

Purpose: The purpose of this proposal is to promulgate permanent regulations regarding authorization and utilization review processes in long stay acute care hospitals, to supersede the temporary emergency regulations which became effective on August 8, 1990.

Summary and analysis: The proposed regulations affect both state regulations governing long stay acute care hospitals (VR 460-04-8.10) and the section of the State Plan for Medical Assistance dealing with Standards Established and Methods Used to Assure High Quality of Care (Attachment 3.1 C).

Long stay acute care hospitals provide specialized services to individuals who require more intensive medical management and nursing care than can normally be provided in nursing facilities. The proposed regulations establish criteria for use both during the admission process and during utilization review, to ensure that the intensive care services offered are appropriate to the patient in question. These criteria do not apply to long stay hospitals serving the mentally ill.

The criteria have been separated to accommodate the differing medical and habilitation needs of adult and pediatric/adolescent patient populations. The following are descriptions of the criteria for each of these categories.

1. Adult Long Stay Acute Care Hospital Criteria: The resident must have long-term health conditions requiring close medical supervision (defined as weekly physician visits), the need for 24-hour licensed nursing care, and the need for specialized services (defined as two out of these rehabilitation services: physical, occupational, speech-language therapies) or specialized equipment. The targeted population includes individuals requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, comprehensive rehabilitative therapy services, and individuals with communicable diseases requiring universal or respiratory precautions.

2. Pediatric/Adolescent Long Stay Acute Care Hospital Criteria: The child (age 21 or younger) must have ongoing health care needs requiring close medical supervision (defined as weekly physician visits), 24-hour licensed nursing supervision, and specialized services (defined as two out of these rehabilitation services; physical, occupational, speech-language therapies) or equipment. The targeted population includes children requiring mechanical ventilation, ongoing intravenous medication or nutrition administration, daily dependence on device-based respiratory or nutritional support (tracheostomy, gastrostomy, etc.), comprehensive rehabilitative therapy services, and children with communicable diseases requiring universal or respiratory precautions (excluding normal childhood diseases such as chicken pox, measles, strep throat, etc.) or terminal illnesses.

In addition, the nursing facility must provide for age-appropriate educational and habilitative needs of children. These individualized services must be appropriate to the child's cognitive level, must meet state educational requirements, and be provided in an organized manner that encourages the child's participation. Services may include, but are not limited to, school, active treatment for mental retardation, habilitative therapies, social skills and leisure activities. Therapeutic leisure services must be provided daily.

The proposed regulations are substantively the same as the temporary emergency regulations promulgated on August 8, 1990, except for rehabilitative service limit requirements. Comments from regulated providers about these limits in

the emergency regulation resulted in proposed language which affords the providers greater flexibility. Technical changes were made for clarity.

Impact: The development of admission criteria and a preauthorization process for long stay acute care hospitals and the implementation of utilization review of Medicaid recipients in such hospitals will help prevent unnecessary expenditures. A recent on site review at one long stay acute care hospital unit indicated that 75% of the residents currently had needs that could be safely and adequately provided in lower levels of care.

This initiative is expected to save DMAS ($350,000) GF in FY 91 and ($350,000) GF in FY 92.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until May 24, 1991.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

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† **June 7, 1991** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **State Plan for Medical Assistance Relating to Occupational/Speech-Language Services and Cost Management Intiatives for PIRS. VR 460-03-3.1100. Amount, Duration, and Scope of Services; VR 460-03-4.1940:1. Nursing Home Payment System; and VR 460-03-4.1943. Cost Reimbursement Limitations.** The proposed amendments would make permanent these three provisions currently existing under emergency regulations: the elimination of cost reimbursement to nursing facilities' licensed in-house pharmacies, limitations of the cost of management services, and reimbursement for occupational and speech/language therapies through nursing facility cost reports.

STATEMENT

Basis and authority: Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:9, for this agency's promulgation of proposed regulations subject to the Department of Planning and Budget's and Governor's reviews. Subsequent to the emergency adoption action and filing with the Registrar of Regulations, the Code requires this agency to initiate the public notice and comment process as contained in Article 2 of the APA. The Board of Medical Assistance Services, in response to the Administration's directive to identify potential cost management initiatives, directed DMAS to eliminate cost reimbursement to nursing facilities' licensed in-house pharmacies, to limit the cost for nursing facilities' management services, and to require that costs of occupational and speech/language therapies rendered to nursing facilities' patients be contained in the facilities' cost reports.

Summary and analysis: The Plan sections affected by this proposed regulation action are the PIRS nursing facility reimbursement methodology (VR 460-03-4.1940:1) and the Amount, Duration, and Scope of Services, Supplement 1 (VR 460-03-3.1100).

DMAS promulgated all three provisions originally as emergency regulations on August 2, 1990. The provisions affecting limitations on management services and elimination of cost reimbursement for in-house pharmacies were tied to the reimbursement methodology on October 1, 1990, these two provisions once again were promulgated as an emergency regulation on October 31, 1990.

Nursing Facilities' In-house Pharmacies Reimbursement:

This provision eliminates cost reimbursement for pharmacy services provided by nursing facilities that operate licensed in-house pharmacies, and requires licensed in-house pharmacies in nursing facilities to submit bills and receive payment for pharmacy services in the same manner as free-standing pharmacies, under separate provider agreements.

This change provides DMAS with a consistent and fair basis and policy for the reimbursement of pharmacy services provided to Medicaid recipients in all nursing facilities by using the effective computerized claims processing system. The Program continues the policy of requiring personal physician fees to be billed directly to DMAS by the physicians.

Limitations on Management Services Expenses:

This provision provides that the ceiling limitation for the costs of management services is the median per diem cost of all management services claimed by all nursing facilities in Virginia. Management services in excess of this ceiling limitation will not be reimbursed by DMAS. Prior to this amendment, the only constraint on the costs of management services was the total operating cost ceiling. This amendment will ensure DMAS that reimbursement will be made only for those management services that are necessary and cost effective.

Therapies Reimbursement through Cost Reports:

This provision eliminates direct payment to enrolled rehabilitation agencies for occupational and speech therapy services provided to Medicaid recipients in nursing homes.

Reimbursement for these services is to be continued through cost reports as provided for in the PIRS methodology. Delivery of medically necessary services is not expected to be affected by this policy.

Impact:

Nursing Facilities' In-house Pharmacies Reimbursement:

The proposed amendment regarding the reimbursement of in-house pharmacies affects twenty-six hospitals and four freestanding nursing facilities in the state of Virginia. The estimated decrease in annual aggregate expenditures for the fiscal years 1991 and 1992 is approximately $300,000 ($150,000 NGF; $150,000 GF) total dollars.

Limitations on Management Services Expenses:

The proposed amendment establishing a limit on the costs of management services affects approximately thirteen nursing facilities with existing management contracts. The estimated decrease in annual expenditures is approximately $600,000 ($300,000 NGF; $300,000 GF) in total dollars for 1991 and 1992.

Therapies Reimbursement through Cost Reports:

The estimated decrease in annual aggregate expenditures is approximately $800,000 ($400,000 NGF; $400,000 GF) in total dollars for FY 91 for the affected 54 rehabilitation agencies.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until June 7, 1991, to Wm. R. Blakely, Jr., Director, Division of Cost Settlement and Audit, 600 East Broad Street, Suite 1300, Richmond, Virginia.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

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† **May 24, 1991** – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Medical Assistance Services intends to amend regulations entitled: **VR 460-04-8.4. Home and Community Based Waiver Services for Elderly and Disabled Individuals.** These regulations control the provision of personal care (respite, adult day health, and personal care) services in the homes of qualifying recipients.

STATEMENT

Basis and authority: Section 32.1-324 of the Code of Virginia grants to the Director of the Department of Medical Assistance Services (DMAS) the authority to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Code also provides, in the Administrative Process Act (APA) § 9-6.14:9, for this agency's promulgation of proposed regulations subject to the Department of Planning and Budget's and Governor's reviews.

Section 1915(c) of the Social Security Act permits states to provide specific Medicaid services to specific Medicaid-eligible individuals without having to provide such services to the entire Medicaid-eligible population, by obtaining a waiver approved by the U.S. Secretary of Health and Human Services.

Purpose: The purpose of this proposal is to promulgate permanent regulations (VR 460-04-8.4) regarding Home and Community Based Services for Elderly and Disabled Individuals, to supersede the temporary emergency regulations which became effective on September 10, 1990.

Summary and analysis: DMAS has provided home and community based services for the elderly and disabled under a Social Security Act waiver approved for the Secretary of Health and Human Services by the Health Care Financing Administration (HCFA) in 1982. Services included under the waiver were personal care, adult day health care and respite care.

As a condition of the waiver, DMAS was required to render a cost-effectiveness assessment of each individual receiving waivered services every six months. The waiver further required that providers obtain prior approval from DMAS for every increase made to any recipient's plan for care.

Because of the resource-intensive requirements of the waiver affecting both providers and DMAS, the Commonwealth sought an amendment to the waiver which would:

eliminate requirement for individual cost-effectiveness assessments while ensuring that the annual aggregate costs to Medicaid are equal to or less than the aggregate costs for institutional care, and

allow providers to use DMAS-developed service limits to serve as standards in developing individual plans of care, which could then be implemented without a prior approval process.

In seeking the waiver amendment, DMAS reasoned that the providers' ability to develop plans of care within established service limits would eliminate 90% of the requests for prior approval being reviewed by DMAS.

HCFA approved Virginia's request to amend the waiver on May 18, 1990. The Governor approved emergency regulations implementing the amended waiver's provisions effective September 10, 1990, based upon DMAS' need to

divert existing resources to the administration of new programs. No adverse impact on either the quality or the cost-effectiveness of services rendered has been experienced since the emergency regulations became effective.

The proposed regulations do not differ substantively from the emergency regulations. They do contain clarification of the definition of adverse action and the DMAS role in assuring compliance with provider participation standards and program policies and procedures. DMAS has also included in these proposed regulations technical corrections to the recipient eligibility requirements which were required by HCFA in the previously discussed waiver approval process.

Impact: These regulations finalize a process that has been underway since early 1990. DMAS has already implemented waiver modifications that are being established in regulations with these changes. Program expenditure estimates for personal care services have not been modified because of these waiver modifications.

Forms: One new form, the Recipient Progress Report, has been implemented and is used by providers to document recipients' status and providers' abilities to render care. The Provider Agency Plan of Care has also been modified.

Statutory Authority: § 32.1-325 of the Code of Virginia.

Written comments may be submitted until May 24, 1991, to Chris Pruett, Analyst, Division of Quality Care Assurance, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

BOARD OF MEDICINE

Chiropractic Examination Committee

April 18, 1991 - 1:30 a.m. – Open Meeting
Department of Health Professions, Board Room 2, 1601 Rolling Hills Drive, Richmond, Virginia.

The committee will meet in executive and closed session to develop test items for the chiropractic examination. Public comments will not be received.

Credentials Committee

April 6, 1991 - 8 a.m. – Open Meeting
Department of Health Professions, Board Room 3, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to conduct general business, interview and review medical credentials of applicants for licensure in Virginia, in open and executive session, and discuss any other items which may come before the committee. Public comments will not be received.

Executive Committee

April 5, 1991 - 9 a.m. – Open Meeting
Department of Health Professions, Board Room 1, 1601 Rolling Hills Drive, Richmond, Virginia.

The committee will meet in open session to review closed cases, cases/files requiring administrative action, and consider any other items which may come before the committee. Public comments will not be received.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Dr., Surry Building, Second Floor, Richmond, VA 23229, telephone (804) 662-9925.

Advisory Committee On Optometry

May 10, 1991 - 10 a.m. – Open Meeting
Department of Health Professions, Board Room 2, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to review and consider other postgraduate training programs for approval for eligibility to sit for the certification examination for the treatment of certain diseases or abnormal conditions of the human eye and its adnexa with certain pharmaceutical agents; and approve completed applications to sit for the certification examination to be held on June 25, 1991. The committee will not receive public comments.

Committee on Certification of Optometry

† **April 12, 1991 - 10 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Board Room 2, Richmond, Virginia.

The committee will meet in open and closed sessions to review postgraduate training courses to be eligible to sit for the certification examination for optometrists to treat certain diseased or abnormal conditions of the human eye and its adnexa with certain therapeutic pharmaceutical agents. Public comments will not be entertained.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Dr., Surry Building, Second Floor, Richmond, VA 23229, telephone (804) 662-9925.

Advisory Board on Physical Therapy

May 3, 1991 - 9 a.m. – Open Meeting
Department of Health Professions, Board Room 2, 1601 Rolling Hills Drive, Richmond, Virginia.

The board will review and discuss regulations, bylaws, procedural manuals, receive reports, and other items

which may come before the advisory board. Public comment will not be received.

STATE MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES BOARD

March 27, 1991 - 10 a.m. – Open Meeting
† **April 24, 1991 - 10 a.m.** – Open Meeting
James Madison Building, 13th Floor Conference Room, Richmond, Virginia. ♿

A regular monthly meeting. The agenda will be published on March 20 for the March 27 meeting and on April 17 for the April 24 meeting, and may be obtained by calling Jane Helfrich.

Tuesday: Informal session - 6 p.m.

Wednesday: Committee meetings 8:45 a.m. and regular session 10 a.m.

See agenda for location.

Contact: Jane Helfrich, Board Administrative, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3912.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

April 8, 1991 - 1 p.m. – Public Hearing
April 8, 1991 - 6 p.m. – Public Hearing
Virginia Housing Authority, Room Number 1, 601 South Belvidere Street, Richmond, Virginia.

April 8, 1991 - 1 p.m. – Public Hearing
April 8, 1991 - 6 p.m. – Public Hearing
Johnston Memorial Hospital, Conference Center, Room C, Abingdon, Virginia.

April 8, 1991 - 1 p.m. – Public Hearing
April 8, 1991 - 6 p.m. – Public Hearing
Central Virginia Training Center, Nagler Building, Lynchburg, Virginia.

April 8, 1991 - 1 p.m. – Public Hearing
April 8, 1991 - 6 p.m. – Public Hearing
Hampton Public Library, 4207 Victoria Boulevard, Hampton, Virginia.

April 8, 1991 - 1 p.m. – Public Hearing
April 8, 1991 - 6 p.m. – Public Hearing
Fairfax Community Services Board, 14601 White Granite Drive, Oakton, Virginia.

Public hearings to receive comments on Virginia's Fourth Year Grant Application to U.S. Department of Education for PL 101-476, Part H, Early Intervention for Infants and Toddlers with Disabilities. Written testimony will be accepted from March 1, 1991 to May 1, 1991 and may be submitted to Early Intervention Program, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services.

Contact: Michael Fehl, Ed.D, Director Mental Retardation, Children and/Youth Services, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3710 or (804) 371-8977/TDD ☎

State Human Rights Committee

† **March 27, 1991 - 10 a.m.** – Open Meeting
Zincke Building, 203 Governor Street, 4th Floor Conference Room, Richmond, Virginia. ♿

A regular meeting to discuss business relating to human rights issues. Agenda items are listed prior to the meeting.

Contact: Elsie D. Little, ACSW, State Human Rights Director, Department of Mental Health, Mental Retardation and Substance Abuse Services, Office of Human Rights, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3988.

DEPARTMENT OF MINES, MINERALS AND ENERGY

March 26, 1991 - 10 a.m. – Public Hearing
Department or Social Services, S.W. Virginia Regional office, 190 Patton Street, Abingdon, Virginia.

March 27, 1991 - 1 p.m. – Public Hearing
General Assembly Building, House Room D, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Mines, Minerals and Energy intends to repeal regulations entitled: **VR 480-05-22. Rules and Regulations for Conservation of Oil and Gas Resources and Well Spacing** and adopt regulations entitled: **VR 480-05-22.1. Gas and Oil Regulations.** The existing regulation governing development, operation, and reclamation of gas and oil operations in Virginia will be repealed concurrently with promulgation of the VR 480-05-22.1 Gas and Oil Regulations which will govern development, operations and reclamation of gas, oil or geophysical operations in Virginia.

Statutory Authority: §§ 45.1-1.3 and 45.1-361.27 of the Code of Virginia.

Written comments may be submitted until March 29, 1991.

Contact: B. Thomas Fuller, Gas and Oil Inspector, Department of Mines, Minerals and Energy, Division of Gas and Oil, P.O. Box 1416, 230 Charwood Dr., Abingdon,

VA 24210, telephone (703) 628-8115, SCATS 676-5501 or toll-free 1-800-552-3831.

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March 26, 1991 - 10 a.m. – Public Hearing
Department or Social Services, S.W. Virginia Regional Office, 190 Patton Street, Abingdon, Virginia.

March 27, 1991 - 1 p.m. – Public Hearing
General Assembly Building, House Room D, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Mines, Minerals and Energy intends to amend regulations entitled: **VR 480-05-96. Regulations Governing Vertical Ventilation Holes and Mining near Gas and Oil Wells.** The regulation provides requirement for safe operation of vertical mine ventilation holes and for safe mining near gas and oil wells.

Statutory Authority: §§ 45.1-1.3(4), 45.1-92.1 and 45.1-104 of the Code of Virginia.

Written comments may be submitted until 5 p.m., March 29, 1991.

Contact: Bill Edwards, Policy Analyst, 2201 W. Broad St., Richmond, VA 23220, telephone (804) 367-0330.

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April 29, 1991 - 10 a.m. – Public Hearing
Virginia Division of Mined Land Reclamation, Upstairs Conference Room, 622 Powell Avenue, Big Stone Gap, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Department of Mines, Minerals and Energy intends to amend regulations entitled: **VR 480-03-19. Coal Surface Mining Reclamation Regulations.** The proposed amendments define ownership and control of coal mining operations for the purpose of tracking outstanding regulatory violations and blocking permitted activity until such violations are abated.

Statutory Authority: §§ 45.1-1.3 and 45.1-230 of the Code of Virginia.

Written comments may be submitted until 5 p.m., April 29, 1991.

Contact: Bill Edwards, Policy Analyst, 2201 W. Broad St., Richmond, VA 23220, telephone (804) 367-0330.

VIRGINIA MUSEUM OF NATURAL HISTORY

Board of Trustees

† **April 20, 1991 - 8 a.m.** – Open Meeting
Dutch Inn Motor Hotel, 633 Virginia Avenue, Collinsville, Virginia. ♿

The meeting will include reports from the executive, finance, education and exhibits, marketing, personnel, planning/facilities, and research and collections committees. Public comment will be received following approval of the minutes of the January meeting.

Contact: Rhonda J. Knighton, Executive Secretary, Virginia Museum of Natural History, 1001 Douglas Ave., Martinsville, VA 24112, telephone (703) 666-8616, SCATS 857-6950/857-6951 or (703) 666-8638/TDD ☎

BOARD OF NURSING

March 25, 1991 - 9 a.m. – Open Meeting
March 26, 1991 - 9 a.m. – Open Meeting
March 27, 1991 - 9 a.m. – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room 1, Richmond, Virginia. ♿

A regular meeting of the board to consider matters related to nursing education programs, discipline of licensees, licensing by examination and endorsement and other matters under the jurisdiction of the board.

Public comment will be received during an open forum session beginning at 11 a.m. on Monday 25, 1991.

Contact: Corinne F. Dorsey, R.N., Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9909, toll-free 1-800-533-1560 or (804) 662-7197/TDD ☎

Special Conference Committee

† **April 9, 1991 - 8:30 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room 1, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to inquire into allegations that certain licensees may have violated laws and regulations governing the practice of nursing in Virginia.

Public comment will not be received

Contact: Corinne F. Dorsey, R.N., Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9909 or toll-free 1-800-533-1560.

BOARD OF NURSING HOME ADMINISTRATORS

May 13, 1991 – Written comments may be submitted until this date.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Nursing Home Administrators intends to amend regulations entitled: **VR 500-01-2:1. Regulations of the Board of Nursing Administrators.** The purpose of the proposed regulations is to establish standards for the practice of nursing home administration.

Statutory Authority: §§ 54.1-2400 and 54.1-3101 of the Code of Virginia.

Written comments may be submitted until May 13, 1991.

Contact: Meredyth P. Partridge, Board Administrator, 1601 Rolling Hills Dr., Richmond, VA 23229, telephone (804) 662-7390.

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE

April 5, 1991 - 1:30 p.m. – Public Hearing
Department of Health Professions, 1601 Rolling Hills Dr., Conference Room 1, Richmond, Virginia. ⊠ (Interpreter for deaf provided upon request)

A public hearing to receive public comments on existing Regulations Governing the Licensure of Nurse Practitioners as a first step in a biennial review of these regulations.

The meeting will be followed by a regular meeting to consider matters related to the regulation of nurse practitioners in the Commonwealth.

Contact: Corinne F. Dorsey R.N., Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229-5005, telephone (804) 662-9909, toll-free 1-800-533-1560 or (804) 662-7197/TDD ☎

BOARD FOR OPTICIANS

† **May 15, 1991 - 9 a.m.** - Public Hearing
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Opticians intends to adopt regulations entitled: **VR 505-01-01:1. Board for Opticians Regulations.** The Board for Opticians proposes to repeal existing regulations and promulgate new regulations to establish the licensing requirements, renewal and reinstatement requirements and standards of practice for opticians in the Commonwealth of Virginia.

STATEMENT

The regulations require licensure of individuals who prepare, dispense and fit lenses and eyeglasses. These regulations apply directly to approximately 1,135 licensed opticians in Virginia.

The proposed regulations have been reorganized to place entry requirements before the requirements for renewal, to include information regarding fees for licensure and to reword some sections to provide clarification of specific requirements. Additions were made to include the requirement that applicants for licensure be in good standing if licensed in another jurisdiction and that they have not been convicted of a felony or misdemeanor in any jurisdiction where licensed or regulated. The regulations also separate the renewal process from the reinstatement process including the addition of progressive penalties for failing to reinstate the license after specific time frames. The authority of the Board to deny license renewal and license reinstatement has also been included in the appropriate section. the amount of the fees throughout the regulation have been adjusted in accordance with § 54.1-113 of the Code of Virginia in order to ensure that the expenses of this program are adequately covered by revenues generated from licensees. In all places where a fee is identified, the statement that the fees are nonrefundable and shall not be prorated is included.

Statutory Authority: §§ 54.1-201 and 54.1-1705 of the Code of Virginia.

Written comments may be submitted until May 27, 1991.

Contact: Pamela M. Templin, Regulatory Programs Intern, Department of Commerce, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8531.

BOARD OF OPTOMETRY

July 18, 1991 - 10 a.m. - Public Hearing
1601 Rolling Hills Dr., Conference Room 1, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Optometry intends to amend regulations entitled: **VR 510-01-1. Regulations of the Virginia Board of Optometry.** The purpose of this action is to amend the regulations for purpose of fee changes, clarification of licensing, examinations, renewal, reinstatement procedures, clarification of unprofessional conduct, and continuing education requirements.

Statutory Authority: § 54.1-2400 and Chapter 32 (§ 54.1-3200 et seq.) of Title 54.1 of the Code of Virginia.

Written comments may be submitted until July 18, 1991.

Contact: Lisa J. Russell, Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229, telephone (804) 662-9915 or SCATS (804) 662-9910.

POLYGRAPH EXAMINERS ADVISORY BOARD

† **April 9, 1991 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

The meeting is for the purpose of administering the Polygraph Examiners licensing examination to eligible polygraph examiner interns and to consider other matters which require board action.

Contact: Geralde W. Morgan, Administrator, Department of Commerce, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8534.

PRIVATE SECURITY SERVICES ADVISORY BOARD

† **April 4, 1991 - 9 a.m.** – Open Meeting
Department of Commerce, 3600 W. Broad St., Richmond, Virginia. ♿

An open meeting to conduct regulatory review.

Contact: Geralde W. Morgan, Administrator, Department of Commerce, 3600 W. Broad St., Richmond, VA 2323-49170, telephone (804) 367-8534.

BOARD OF PROFESSIONAL COUNSELORS

† **April 18, 1991 - 10 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

Oral Examiners' Training Workshop.

Contact: Joyce D. Williams, Administrative Assistant, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9912.

† **April 19, 1991 - 9 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

A board meeting to consider general business committee reports, and regulatory review. No public comments will be received.

Contact: Evelyn B. Brown, Executive Director or Joyce D. Williams, Administrative Assistant, Department of Health Professions, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9912.

BOARD FOR PROFESSIONAL SOIL SCIENTISTS

† **April 1, 1991 - 1 p.m.** – Open Meeting
3600 W. Broad St., Richmond, Virginia. ♿

A general board meeting.

Contact: Nelle P. Hotchkiss, Assistant Director, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595.

BOARD OF PSYCHOLOGY

Examination Committee

† **May 3, 1991 - 9 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room 4, Richmond, Virginia. ♿

† **June 28, 1991 - 9 a.m.** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Conference Room 2, Richmond, Virginia. ♿

A regular meeting of the committee. Public comment will not be received.

Contact: Evelyn Brown, Executive Director, 1601 Rolling Hills Drive, Suite 200, Richmond, VA 23229-5005, telephone (804) 662-9913 or (804) 662-7197/TDD ☎

VIRGINIA PUBLIC TELECOMMUNICATIONS BOARD

† **April 11, 1991 - 10 a.m.** – Open Meeting
Location To Be Announced, Richmond, Virginia.

A regularly scheduled quarterly meeting to consider approval of the Planning Committee's recommendations on the revised Master Plan for Public Telecommunications. Other agenda items include the 1991 legislative update, allocation of grants and contracts for 1991-92, budget planning for 1992-94, and updates on other items of interest.

Contact: Mamie White, Administrator Assistant to the Virginia Public Telecommunications Board, 110 S. Seventh St., 1st Floor, Richmond, VA 23219, telephone (804) 344-5522.

VIRGINIA RACING COMMISSION

April 17, 1991 - 9:30 a.m. – Public Hearing
VSRS Building, 1204 East Main Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Racing Commission intends to adopt regulations entitled: **VR 662-03-02. Regulations Pertaining to Horse Racing with Pari-Mutuel Wagering: Participants.** This proposed regulation establishes the duties,

qualifications and responsibilities of participants in horse racing.

Contact: William H. Anderson, Policy Analyst, Virginia Racing Commission, P.O. Box 1123, Richmond, VA 23208, telephone (804) 371-7363.

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April 17, 1991 - 9:30 a.m. – Public Hearing
VSRS Building, 1204 East Main Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Racing Commission intends to adopt regulations entitled: **VR 662-04-03. Regulations Pertaining to Horse Racing with Pari-Mutuel Wagering: Claiming Races.** This proposed regulation establishes procedures and conditions under which claiming races will be conducted at horse racing facilities licensed by the commission.

Statutory Authority: § 59.1-369 of the Code of Virginia.

Written comments may be submitted until April 26, 1991.

Contact: William H. Anderson, Policy Analyst, Virginia Racing Commission, P.O. Box 1123, Richmond, VA 23208, telephone (804) 371-7363.

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April 17, 1991 - 9:30 a.m. – Public Hearing
VSRS Building, 1204 East Main Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Racing Commission intends to adopt regulations entitled: **VR 662-05-02. Regulations Pertaining to Horse Racing with Pari-Mutuel Wagering: Standardbred Racing.** The proposed regulation will establish the conditions, procedures and driving rules for the conduct of Standardbred racing.

Statutory Authority: § 59.1-369 of the Code of Virginia.

Written comments may be submitted until May 13, 1991.

Contact: William H. Anderson, Policy Analyst, Virginia Racing Commission, P.O. Box 1123, Richmond, VA 23208, telephone (804) 371-7363.

REAL ESTATE BOARD

† **March 25, 1991 - 10:30 a.m.** – Open Meeting
Tysons Corner Marriott, 8028 Leesburg Pike, Vienna, Virginia.

The Real Estate Board will meet to conduct a formal hearing: File Number 89-001137, Real Estate Board v. Frank M. Connell, Jr.

Contact: Gayle Eubank, Hearings Coordinator, Department of Commerce, 3600 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 367-8524.

BOARD OF REHABILITATIVE SERVICES

† **March 28, 1991 - 10 a.m.** – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The March board meeting will be devoted to board policy and the role of the board.

Finance Committee

† **March 28, 1991 - 9 a.m.** – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review monthly financial reports and budgetary projections.

Legislation and Evaluation Committee

† **March 28, 1991 - 9 a.m.** – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

Legislative update.

Program Committee

† **March 28, 1991 - 9 a.m.** – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to consider the WWRC Program Report, Independent Living Update and regulations review.

Contact: Susan L. Urofsky, Commissioner, 4901 Fitzhugh Avenue, Richmond, VA 23230, telephone (804) 367-0319, toll-free 1-800-552-5019 TDD and Voice or (804) 367-0280/TDD ☎

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

April 26, 1991 - 10 a.m. – Public Hearing
Tyler Building, Suite 220, Conference Room, 8007 Discovery Drive, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Social Services intends to amend regulations entitled: **VR 615-08-01. Virginia Energy Assistance Program.** The proposed amendment will change the Cooling Assistance start date to July 1, 1991.

Statutory Authority: § 63.1-25 of the Code of Virginia.

Written comments may be submitted until April 26, 1991, to Charlene H. Chapman, Department of Social Services, 8007 Discovery Drive, Richmond, Virginia.

Contact: Peggy Friedenberg, Legislative Analyst, 8007 Discovery Dr., Richmond, VA 23229-8699, telephone (804) 662-9217.

STATE CORPORATION COMMISSION

March 26, 1991 - 10 a.m. – Open Meeting
State Corporation Commission, Jefferson Building, 13th Floor Courtroom, Bank and Governor Streets, Richmond, Virginia.

A meeting to consider promulgation of regulations relating to Road Tax on Motor Carriers.

Contact: Graham G. Ludwig, Jr., State Corporation Commission, P.O. Box 1197, Richmond, VA 23209, telephone (804) 786-8671. Persons wishing to speak should contact William J. Bridge, Clerk, State Corporation Commission, P.O. Box 1197, Richmond, VA 23209, telephone (804) 786-3672.

COMMONWEALTH TRANSPORTATION BOARD

† **April 17, 1991 - 2 p.m.** – Open Meeting
Virginia Department of Transportation, Board Room, 1401 E. Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A work session of the board and the Department of Transportation staff.

† **April 18, 1991 - 10 a.m.** – Open Meeting
Virginia Department of Transportation, Board Room, 1401 E. Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A monthly meeting to vote on proposals presented regarding bids, permits, additions and deletions to the highway system, and any other matters requiring board approval. Public comment will be received at the outset of the meeting on items on the meeting agenda for which the opportunity for public comment has not been afforded the public in another forum. Remarks will be limited to five minutes. Large groups are asked to select one individual to speak for the group. The board reserves the right to amend these conditions.

Contact: John G. Milliken, Secretary of Transportation, 1401 E. Broad Street, Richmond, VA 23219, telephone (804) 786-6670.

TREASURY BOARD

April 17, 1991 - 9 a.m. – Open Meeting
James Monroe Building, 101 North 14th Street, 3rd Floor, Treasury Board Conference Room, Richmond, Virginia. ♿

A regularly scheduled meeting of the board.

Contact: Laura Wagner-Lockwood, Senior Debt Manager, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-4931.

BOARD FOR THE VISUALLY HANDICAPPED

† **April 20, 1991 - 11 a.m.** – Open Meeting
397 Azalea Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A quarterly meeting to review policy and procedures of the Virginia Department for the Visually Handicapped. The board will review and comment on the department's budget.

Contact: Joseph Bowman, Executive Assistant, 397 Azalea Avenue, Richmond, VA 23227, telephone (804) 371-3140 or toll-free 1-800-622-2155.

DEPARTMENT FOR THE VISUALLY HANDICAPPED

Advisory Committee on Services

April 20, 1991 - 11 a.m. – Open Meeting
Rehabilitation Center for the Blind, 401 Azalea Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to consider matters related to services for blind and visually handicapped citizens of the Commonwealth.

Contact: Barbara G. Tyson, Executive Secretary, 397 Azalea Avenue, Richmond, VA 23227, telephone (804) 371-3350, toll-free 1-800-622-2155 or 371-3140/TDD ☎

VIRGINIA COUNCIL ON VOCATIONAL EDUCATION

† **March 27, 1991 - 1 p.m.** – Open Meeting
† **March 28, 1991 - 10 a.m.** – Open Meeting
Jefferson Sheraton Hotel, Franklin and Main Streets, Richmond, Virginia.

March 27, 1991 - 1 p.m. Business Session; 2 p.m. Work Session.

March 28, 1991 - 10 a.m. Tentative meeting with the Virginia Board of Education.

Contact: George S. Orr, Jr., Executive Director, Virginia

Council on Vocational Education, 7420-A Whitepine Road, Richmond, VA 23227, telephone (804) 275-6218.

VIRGINIA VOLUNTARY FORMULARY BOARD

April 17, 1991 - 10 a.m. – Public Hearing
109 Governor Street, Main Floor Conference Room, Richmond, Virginia.

The purpose of this hearing is to consider the proposed adoption and issuance of revisions to the Virginia Voluntary Formulary. The proposed revisions to the Formulary add and delete drugs and drug products to the Formulary that became effective on April 23, 1990, and the most recent supplement to that Formulary. Copies of the proposed revisions to the Formulary are available for inspection at the Virginia Department of Health, Bureau of Pharmacy Services, James Madison Building, 109 Governor Street, Richmond, Virginia 23219. Written comments sent to the above address and received prior to 5 p.m. on April 17, 1991, will be made a part of the hearing record and considered by the Board.

Contact: James K. Thomson, Director Bur Pharmacy Services, 109 Governor St., Room B1-9, Richmond, VA 23219, telephone (804) 786-4326 or 786-3596.

VIRGINIA WASTE MANAGEMENT BOARD

April 15, 1991 - 10 a.m. – Open Meeting
Monroe Building, 11th Floor, 101 North 14th Street, Richmond, Virginia. &

An informational meeting will be held for Amendment 9 to the Regulations Governing the Transportation of Hazardous Materials. The proposed amendment will incorporate by reference changes that were made by U.S. DOT to Title 49 Code of Federal Regulations from July 1, 1989, to June 30, 1990. Therefore, this amendment (with the possible exception of the requirements relating to mandatory drug testing program) is not expected to have a significant impact on the regulated community.

Contact: C. Ronald Smith, Hazardous Waste Enforcement Chief, Virginia Department of Waste Management, 11th Fl., Monroe Bldg., 101 N. 14th St., Richmond, VA 23219, telephone (804) 225-2667 or toll-free 1-800-552-2075.

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April 15, 1991 - 11 a.m. – Public Hearing
Monroe Building, 101 North 14th Street, 11th Floor, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Virginia Waste Management Board intends to amend regulations entitled: **VR 672-30-1. Regulations Governing the Transportation of Hazardous Materials.** The purpose of the amendments is to incorporate by reference changes that were made by U.S. DOT to Title 49 Code of Federal Regulations from July 1, 1989 to June 30, 1990.

Statutory Authority: §§ 10.1-1402 and 10.1-1450 of the Code of Virginia.

PLEASE NOTE CHANGE IN WRITTEN COMMENTS DATE
Written comments may be submitted until April 15, 1991, to William E. Gilley, P.E., Director of Regulation, Department of Waste Management, 101 N. 14th St., 11th Floor, Monroe Bldg., Richmond, Va.

Contact: C. Ronald Smith, Hazardous Waste Enforcement Chief, 11th Fl., Monroe, Bldg., 101 N. 14th St., Richmond, VA 23219, telephone (804) 225-2667 or toll-free 1-800-552-2075.

STATE WATER CONTROL BOARD

March 25, 1991 - 9 a.m. – Open Meeting
March 26, 1991 - 9 a.m. – Open Meeting
General Assembly Building, Senate Room B, 9th and Broad Streets, Richmond, Virginia.

A regular quarterly meeting.

Contact: Doneva A. Dalton, Office of Policy Analysis, State Water Control Board, P.O. Box 11143, 2111 N. Hamilton St., Richmond, VA 23230, telephone (804) 367-6829.

BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS

March 27, 1991 - 8:30 a.m. – Open Meeting
March 28, 1991 - 8:30 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. &

An open meeting to conduct regulatory review.

Contact: Geralde W. Morgan, Administrator, Department of Commerce, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8534.

THE COLLEGE OF WILLIAM AND MARY

Board of Visitors

† **April 11, 1991 - 3 p.m.** – Open Meeting
† **April 12, 1991 - 7:30 a.m.** – Open Meeting
Blow Memorial Hall, Richmond Road, Williamsburg, Virginia.

A regularly scheduled meeting of the board to (i) approve the budgets and fees of the College and Richard Bland College, (ii) receive reports from several committees of the Board, and (iii) act on those resolutions that are presented by the administrations of William and Mary and Richard Bland College.

An informational release will be available four days prior to the board meeting for those individuals and organizations who request it.

Contact: William N. Walker, Director, Office of University Relations, James Blair Hall, Room 101C, College of William and Mary, Williamsburg, VA 23185, telephone (804) 221-1004.

VIRGINIA WINEGROWERS ADVISORY BOARD

April 8, 1991 - 10 a.m. – Open Meeting
Oakencroft Vineyard and Winery, Charlottesville Virginia.

The board will hear reports from Committee chairs and project monitors, and review old and new business. The board will also hear and vote on new project proposals for the 91-92 Fiscal Year.

Contact: Annette C. Ringwood, Wine Marketing Specialist, 1100 Bank St., Suite 1010, Richmond, VA 23219, telephone (804) 371-7685

VIRGINIA DEPARTMENT OF
YOUTH & FAMILY SERVICES
Youth Begins With You.

BOARD OF YOUTH AND FAMILY SERVICES

† **May 9, 1991 - 10 a.m.** – Open Meeting
Natural Bridge Learning Center, Natural Bridge, Virginia.

A general business meeting of the board.

Contact: Paul E. Steiner, Regulatory Coordinator, 700 Centre Building, 4th Floor, 7th and Franklin Streets, Richmond, VA 23219, telephone (804) 371-0700.

LEGISLATIVE

LOCAL AND STATE GOVERNMENT INFRASTRUCTURE AND REVENUE RESOURCES COMMISSION

† **April 2, 1991 - 9:30 a.m.** – Open Meeting
State Capitol Building, House Room 1, Richmond, Virginia.

A work session. HJR 205

Contact: John Garka, Manager, Division of Legislative Services, 910 Capitol St., Richmond, VA 23219, telephone (804) 786-3591.

CHRONOLOGICAL LIST

OPEN MEETINGS

March 25
† ASAP Policy Board, Central, Virginia
† Cosmetology, Board for
† Geology, Board for
Lottery Board, State
Nursing, Board of
Real Estate Board
Water Control Board, State

March 26
Contractors, Board for
- Recovery Fund Committee
† Cosmetology, Board for
† Hazardous Materials Training Committee
Health Services Cost Review Council, Virginia
Marine Resources Commission, Virginia
Nursing, Board of
State Corporate Commission
Water Control Board, State

March 27
Council on Indians
Medical Assistance Services, Board of
Mental Health, Mental Retardation and Substance Abuse Services Board, State
- Human Rights Committee, State
Nursing, Board of
† Vocational Education, Virginia Council on
Waterworks and Wastewater Works Operators, Board for

March 28
Aging, Department for the
- Long-Term Care Ombudsman Program Advisory Council
Contractors, Board for
† Court Appointed Special Advocate and Children's Justice Act - Advisory Committee
Education, Board of
Labor and Industry, Department of
- Virginia Apprenticeship Council
† Rehabilitative Services, Board of
- Finance Committee
- Legislation and Evaluation Committee
- Program Committee
† Vocational Education, Virginia Council on
Waterworks and Wastewater Works Operators, Board for

March 29
Education, Board of

April 1
† Professional Soil Scientists, Board for

April 2
† Hopewell Industrial Safety Council
† Local and State Government Infrastructure and Revenue Resources Commission

April 3
† ASAP Policy Board, Mount Rogers
† Criminal Justice Services Board
- Committee on Training
† Higher Education, State Council of
† Longwood College
- Academic/Student Affairs Committee

April 4
Chesapeake Bay Local Assistance Board
Emergency Planning Committee, Local - Chesterfield County
† Medical Assistance Services, Department of
† Private Security Services Advisory Board

April 5
† Aging, Department for the
Medicine, Board of
- Executive Committee
Nursing and Medicine, Committee of the Joint Boards

April 6
Medicine, Board of
- Credentials Committee

April 8
† Barbers, Board for
Winegrowers Advisory Board, Virginia

April 9
† Nursing, Board of
- Special Conference Committee
† Polygraph Examiners Advisory Board

April 10
Funeral Directors and Embalmers, Board of

April 11
† Health, Department of
† Public Telecommunications Board, Virginia
† William and Mary, The College of

April 12
† Medicine, Board of
- Committee on Certification of Optometry
† William and Mary, The College of

April 15
† Cattle Industry Board, Virginia
† Medical Assistance Services, Board of
Waste Management, Department of

April 16
† Cattle Industry Board, Virginia
† Historic Resources, Department of
- State Review Board
† Labor and Industry, Department of
- Safety and Health Codes Board

April 17
Corrections, Board of
† Historic Resources, Board of
† Transportation Board, Commonwealth
Treasury Board

April 18
Conservation and Recreation, Department of
- Guest Scenic River Advisory Board
Medicine, Board of
- Chiropractic Examination Committee
† Professional Counselors, Board of
† Transportation Board, Commonwealth

April 19
Funeral Directors and Embalmers, Board of
Interdepartmental Regulation of Residential Facilities for Children
- Coordinating Committee
† Joint Board Liaison Committee
† Professional Counselors, Board of

April 20
† Museum of Natural History, Virginia
- Board of Trustees
Visually Handicapped, Board for the
Visually Handicapped, Department for the
- Advisory Committee on Services

April 22
Emergency Response Council, Virginia

April 23
† Health Services Cost Review Council, Virginia

April 24
Dentistry, Board of
† Emergency Planning Committee, Local - Gloucester County
Mental Health, Mental Retardation and Substance Abuse Services Board, State

April 25
† Commerce, Board of
Compensation Board
Dentistry, Board of
Emergency Planning Committee, Local - Arlington County/City of Falls Church

April 26
Dentistry, Board of

April 27
Dentistry, Board of

April 28
Longwood College
- Board of Visitors

April 29
Local Government, Commission on
Longwood College
- Board of Visitors

April 30
Local Government, Commission on

May 1
Local Government, Commission on

May 2
Emergency Planning Committee, Local - Chesterfield County

May 3
Medicine, Board of
- Advisory Board on Physical Therapy
† Psychology, Board of
Examination Committee

May 6
† Funeral Directors and Embalmers, Board of

May 8
† Interagency Coordinating Council

May 9
† Youth and Family Services, Board of

May 10
Medicine, Board of
- Advisory Committee on Optometry

May 23
† Audiology and Speech Pathology, Board of
† Agriculture and Consumer Services, Board of

June 6
† Emergency Planning Committee, Local - Chesterfield County

June 28
† Psychology, Board of
- Examination Committee

PUBLIC HEARINGS

March 26
Air Pollution Control, Department of
Mines, Minerals and Energy, Department of

March 27
Mental Health, Mental Retardation and Substance Abuse Services, Department of
Mines, Minerals and Energy, Department of

March 28
Council on Child Day Care and Early Childhood Programs, Virginia

April 4
Council on Child Day Care and Early Childhood Programs, Virginia

April 10
Council on Child Day Care and Early Childhood Programs, Virginia

April 15
Health Professions, Department of
- Regulatory Research Committee
Waste Management, Department of

April 17
Racing Commission, Virginia
Virginia Voluntary Formulary Board

April 24
† Air Pollution Control Board, State
† Commerce, Board of

April 25
Health, Department of

April 26
Social Services, Department of

April 27
Dentistry, Board of

April 29
Mines, Minerals and Energy, Department of

April 30
Local Government, Commission on

May 10
Agriculture and Consumer Services, Department of
- Pesticide Control Board

May 15
† Opticians, Board for

May 23
† Agriculture and Consumer Services, Department of

June 4
† Aging, Department for the

June 5
† Aging, Department for the

June 12
† Aging, Department for the

Calendar of Events

June 13
† Aging, Department for the

June 26
† Aging, Department for the

July 18
Optometry, Board of