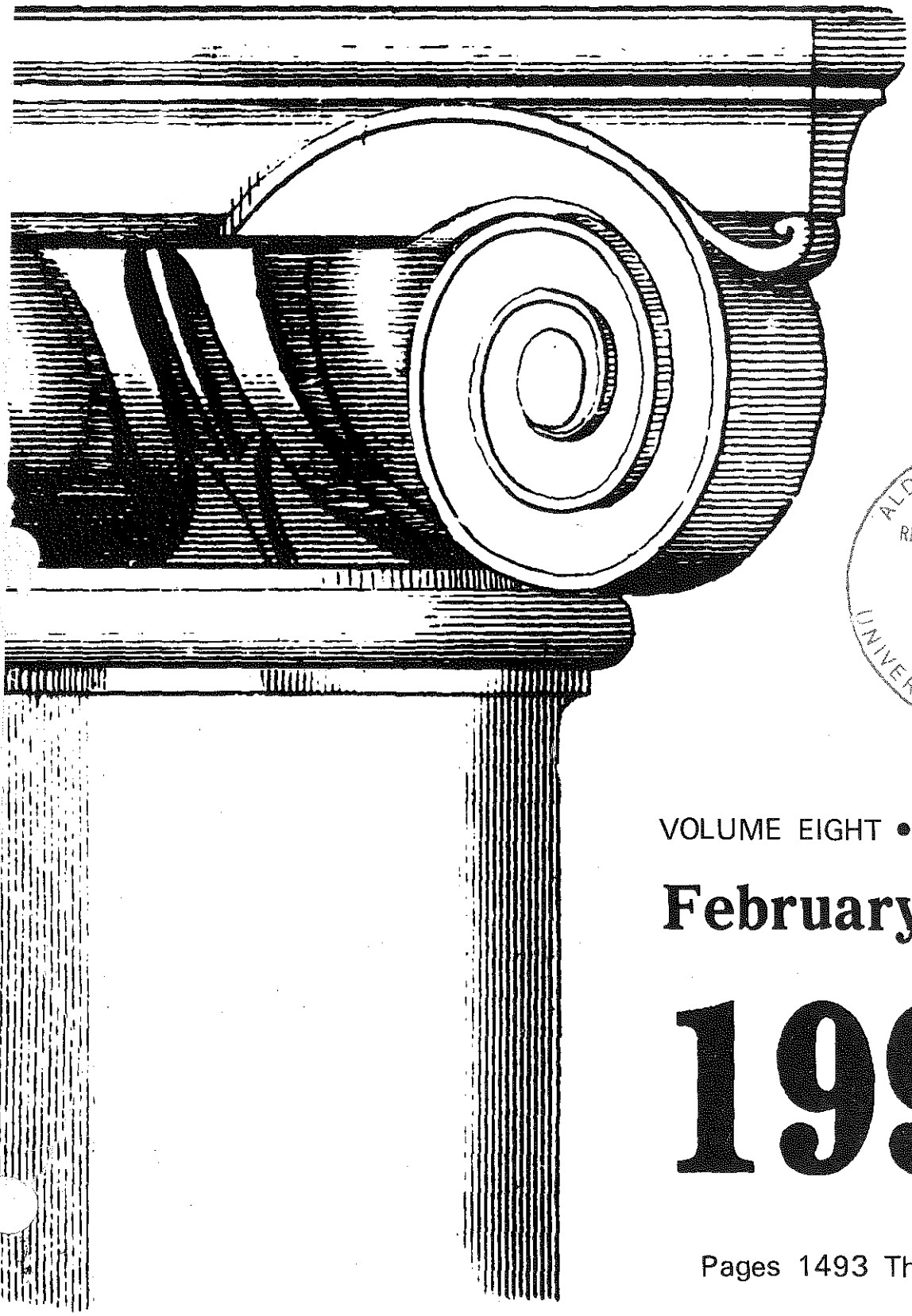
THE VIRGINIA REGISTER

OF REGULATIONS



VOLUME EIGHT • ISSUE TEN

February 10, 1992

1992

Pages 1493 Through 1644

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.

"The Virginia Register of Regulations" (USPS-001831) is published bi-weekly, except four times in January, April, July and October for $100 per year by the Virginia Code Commission, General Assembly Building, Capitol Square, Richmond, Virginia 23219. Telephone (804) 786-3591. Second-Class Postage Rates Paid at Richmond, Virginia. **POSTMASTER:** Send address changes to the Virginia Register of Regulations, 910 Capitol Street, 2nd Floor, Richmond, Virginia 23219.

The Virginia Register of Regulations is published pursuant to Article 7 of Chapter 1.1:1 (§ 9-6.14:2 et seq.) of the Code of Virginia. Individual copies are available for $4 each from the Registrar of Regulations.

VIRGINIA REGISTER OF REGULATIONS

PUBLICATION DEADLINES AND SCHEDULES

July 1991 though September 1992

MATERIAL SUBMITTED BY Noon Wednesday	PUBLICATION DATE
June 26	July 15
July 10	July 29
July 24	Aug. 12
Aug. 7	Aug. 26
Aug. 21	Sept. 9
Sept. 4	Sept. 23
Final Index - Volume 7	
Volume 8 - 1991-92	
Sept. 18	Oct. 7
Oct. 2	Oct. 21
Oct. 16	Nov. 4
Oct. 30	Nov. 18
Nov. 13	Dec. 2
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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 amend § 6.3 of the council's existing regulations to set specific guidelines for when a proposed amendment or modification of a health care institution's current charge schedule is excessive or inadequate.

Statutory Authority: §§ 9-161 D and 9-164 2 of the Code of Virginia.

Written comments may be submitted until February 21, 1992.

Contact: John A. Rupp, Director, 805 E. Broad Street, 6th Floor, Richmond, VA 23219, telephone (804) 786-6371.

STATE LOTTERY DEPARTMENT (STATE LOTTERY BOARD)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Lottery Board intends to consider amending regulations entitled: **VR 447-01-2. Administration Regulations; VR 447-02-1. Instant Game Regulations; and VR 447-02-2. On-line Game Regulatioins.** The purpose of the proposed action is to (i) introduce subscription services, a new on-line lottery program; (ii) clarify the prize amount that can be paid by lottery retailers as a result of implementation of Pick 4; and (iii) conform existing regulations to current law.

Statutory Authority: § 58.1.4007 of the Code of Virginia.

Written comments may be submitted until March 13, 1992.

Contact: Barbara L. Robertson, Lottery Staff Officer, 2201 West Broad Street, Richmond, VA 23220, telephone (804) 367-9433.

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: **Department of Education Access to Medicaid Services.** The purpose of the proposed action is to allow school divisions to become Medicaid providers for their students and allow the school division to bill Medicaid for those covered services.

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

Written comments may be submitted until 4:30 p.m, February 24, 1992, to Jeff Nelson, Policy Analyst, Division of Policy and Research, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad Street, 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 promulgating regulations entitled: **Managed Care (Medallion Program).** The purpose of the proposed action is to promulgate regulations for the Medallion Program of managed care.

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

Written comments may be submitted until 4:30 p.m, February 24, 1992, to Tom Bone, Director, Division of Managed Care, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad Street, 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: **Methods and Standards for Establishing Payment Rates–Inpatient Hospital Services: Disproportionate Share Adjustments for State Teaching Hospitals.** The purpose of the proposed action is to promulgate permanent regulations to supersede the existing emergency regulations providing for the same policy.

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

Written comments may be submitted until 4:30 p.m, February 24, 1992, to Wm. R. Blakely, Jr., Director, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad Street, 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: **Methods and Standards for Establishing Payment Rates–Inpatient Hospital Services: Outlier Adjustment Payments.** The purpose of the proposed action is to promulgate permanent regulations to supersede the existing emergency regulations for the same policy, which resulted from § 4606 of the Omnibus Budget Reconciliation Act of 1990.

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

Written comments may be submitted until 4:30 p.m, February 24, 1992, to Wm. R. Blakely, Jr., Director, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad Street, 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: **VR 460-03-4.1921. Obstetric/Pediatric Maximum Fees.** The purpose of the proposed action is to promulgate updates to the existing obstetric/pediatric fees currently contained in Attachment 4.19 B, Supplement 1.

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

Written comments may be submitted until 4:30 p.m, February 24, 1992, to Len Varmette, Manager, Division of Client Services, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad Street, 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 promulgating regulations entitled: **Transportation Program.** The purpose of the proposed action is to promulgate permanent regulations to supersede the existing emergency regulations which provide for the discontinuing of the prior authorization requirement for transportation services.

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

Written comments may be submitted until 4:30 p.m, February 24, 1992, to Bernie Pomfrey, Manager, Division of Client Services, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-7933.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (STATE BOARD)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the State Mental Health, Mental Retardation and Substance Abuse Services Board intends to consider promulgating regulations entitled: **Certification of Therapeutic Consultation and Residential Services.** The purpose of the proposed action is to promulgate permanent regulations which set requirements for providers of therapeutic consultation and residential services under the Mental Retardation waiver.

Statutory Authority: §§ 37.1-10 and 37.1-179.1 of the Code of Virginia.

Written comments may be submitted until March 10, 1992, to Ben Saunders, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214.

Contact: Rubyjean Gould, Director of Administrative Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3915.

BOARD OF NURSING HOME ADMINISTRATORS

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Nursing Home Administrators intends to consider amending regulations entitled: **VR 500-02-2:1. Regulations of the Board of Nursing Home Administrators.** The purpose of the proposed action is to provide flexibility by including another route to licensure through relaxed qualifications.

Statutory Authority: §§ 54.1-100 through 54.1-114, 54.1-2400 through 54.1-2403, 54.1-2500 through 54.1-2510, and 54.1-3100 through 54.1-3103 of the Code of Virginia.

Written comments may be submitted until March 12, 1992.

Contact: Meredyth P. Partridge, Executive Director, Board

of Nursing Home Administrators, 1601 Rolling Hills Drive, Richmond, Virginia 23229, telephone (804) 662-9111.

BOARD OF PROFESSIONAL COUNSELORS

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board of Professional Counselors intends to consider amending regulations entitled: **560-01-02. Regulations Governing the Practice of Professional Counseling.** The purpose of the proposed action is to consider the deletion of oral examinations for professional counselor licensure. The board is extending the period of comment to allow for additional public input regarding oral examinations.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Written comments may be submitted until March 10, 1992.

Contact: Evelyn B. Brown, Executive Director, Board of Professional Counselors, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9912.

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: **VR 615-08-01. Virginia Energy Assistance Program.** The purpose of the proposed action is to plan policies and procedures for implementation in the 1992-93 program year. Based on problems identified, procedural modification will occur. Regulatory requirements are contained in Title VI of the Human Services Reauthorization Act of 1990 (Public Law 101-501).

Statutory Authority: § 63.1-25 of the Code of Virginia.

Written comments may be submitted until March 10, 1992, to Charlene H. Chapman, Virginia Department of Social Services, Division of Benefit Programs, 8007 Discovery Drive, Richmond, VA 23229-8699.

Contact: Peggy Friedenberg, Legislative Analyst, Bureau of Governmental Affairs, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

DEPARTMENT OF WASTE MANAGEMENT (VIRGINIA WASTE MANAGEMENT BOARD)

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Virginia Waste Management Board intends to consider amending regulations entitled: **VR 672-20-10. Solid Waste Management Regulations.** The purpose of the proposed action is to update the 1988 regulations including requirements of the newly promulgated federal Solid Waste Disposal Facility Criteria.

Statutory Authority: § 10.1-1402 of the Code of Virginia.

Written comments may be submitted until April 1, 1992.

Contact: Wladimir Gulevich, Department of Waste Management, 101 N. 14th Street, 11th Floor, Monroe Building, Richmond, VA 23219, telephone (804) 225-2667.

BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS

Notice of Intended Regulatory Action

Notice is hereby given in accordance with this agency's public participation guidelines that the Board for Waterworks and Wastewater Works Operators intends to consider amending regulations entitled: **VR 675-01-02. Board for Waterworks and Wastewater Works Operators.** The purpose of the proposed action is to initiate a review process to consider adjusting fees charged by the board.

Statutory Authority: § 54.1-201(5) of the Code of Virginia.

Written comments may be submitted until March 2, 1992.

Contact: Geralde W. Morgan, Administrator, Department of Commerce, 3600 West Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8534.

For information concerning Proposed Regulations, see information page.

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.

BOARD FOR CONTRACTORS

Title of Regulation: **VR 220-01-2. Rules and Regulations of the Board for Contractors.**

Statutory Authority: § 54.1-1102 of the Code of Virginia.

Public Hearing Date: February 19, 1992 - 6 p.m.
(See Calendar of Events section for additional information)

Summary:

The proposed regulations have been amended to (i) define the specialty services which contractors may perform under the "specialty contractors" license classification, (ii) eliminate the $15,000 net work entry requirement for Class B contractors, (iii) provide a section on the filing of charges under standards of conduct, and (iv) include two new prohibited acts. In addition, these proposed changes provide regulatory revisions and amended language for the purpose of clarification, as well as a reduction in the fees that can be required for trade-related examinations offered by the Board for Contractors.

VR 220-01-2. Rules and Regulations of the Board for Contractors.

PART I.
GENERAL.

§ 1.1. Definitions of *license* classifications.

The following words and terms, when used in these regulations, unless a different meaning is provided or is plainly required by the context, shall have the following meanings:

"Building contractors" (Abbr: BLD) are those whose contracts include construction on real property owned, controlled or leased by another person of commercial, industrial or institutional buildings *or structures* , or single or multiple-family residential buildings, including accessory-use structures, and the remodeling, repair ~~or~~ , improvement *or dismantling* of any size building.

"Highway/heavy contractors" (Abbr: H/H) are those whose contracts include construction of roads, streets, bridges, railroads, public transit systems, runways, dams, parking lots, *towers, tanks, structural signs and lights, foundations and miscellaneous drainage structures, or the dismantling thereof, or involve* demolition, clearing, grading, excavating, paving, *road markings,* pile driving ~~, foundations and miscellaneous drainage structures~~ *or nonwater well drilling* . Also included are those whose contracts include the installation ~~or~~ , maintenance *or dismantling* of power systems for the generation and primary and secondary distribution of electric current ahead of the customer's meter; the installation ~~or~~ , maintenance *or dismantling* of telephone, telegraph or signal systems for public utilities; and the installation , *maintenance of dismantling* of water, gas, and sewer lines, pumping stations, and treatment plants.

~~"Specialty contractors" are those whose contracts are for specialty services which do not substantially fall within the scope of any other classification within these regulations.~~

"Electrical contractors" (Abbr: ELE) are those whose contracts include construction *or removal* which falls within the provisions of the National Electrical Code.

"Plumbing contractors" (Abbr: PLB) are those whose contracts include the installation, maintenance, extension, ~~or~~ alteration *or removal* of all piping, fixtures, appliances, and appurtenances in connection with any of the following: sanitary or storm drainage facilities; the venting system and the public or private water supply systems within or adjacent to any building, structure or conveyance; also the practice and materials used in the installation, maintenance, extension, or alteration of storm-water, liquid waste, or sewerage, and water supply systems of any premises to their connection with any point of public disposal or other acceptable terminal.

"HVAC contractors" (Abbr: HVA) are those whose work includes the installation, alteration, or repair of heating systems, ventilating systems, cooling systems, steam and hot water heating systems, boilers, and mechanical refrigeration systems.

"Specialty contractors" (Abbr: SVC) are those whose contracts are for specialty services which do not substantially fall within the scope of any other classification within these regulations.

§ 1.2. Definitions of specialty services performed under the specialty contractors license classification.

The following words and terms shall have the following meanings with regard to specialty services:

"Alarm/security systems contracting" (Abbr: ALS) is that service which provides for the installation, repair, improvement or removal of alarm systems or security systems annexed to real property. (Note: Excluding the installation of applicable and incidental locking devises, no

other license classification or specialty service provides for this function.)

"Appliance/fixture contracting" (Abbr: APF) is that service which provides for the installation, addition, repair, improvement or removal of appliances or fixtures annexed to real property, excluding gas appliances or fixtures. (Note: No other license classification or specialty service provides for this function.)

"Asbestos contracting" (Abbr: ASB) is that service which provides for the removal, encapsulation or installation of asbestos containing materials annexed to real property. (Note: No other license classification or specialty service provides for this function.)

"Billboard/sign contracting" (Abbr: BSC) is that service which provides for the installation, repair, improvement or dismantling of any billboard or structural sign permanently annexed to real property. (Note: The highway/heavy license classification also provides for this function.)

"Blast/explosive contracting" (Abbr: BEC) is that service which provides for the use of explosive charges for the repair, improvement, alteration or demolition of any real property or any structure annexed to real property. (Note: This function can only be performed in conjunction with the highway/heavy license classification.)

"Commercial improvement contracting" (Abbr: CIC) is that service which provides for additions, repairs or improvements to nonresidential buildings or structures or nonresidential accessory-use structures annexed to real property. (Note: The building license classification also provides for this function.)

"Electronic systems contracting" (Abbr: ESC) is that service which provides for the installation, repair, improvement or removal of electronic systems annexed to real property. (Note: No other license classification or specialty service provides this function.)

"Elevator/escalator contracting" (Abbr: EEC) is that service which provides for the installation, repair, improvement or removal of elevators or escalators permanently annexed to real property. (Note: No other license classification or specialty service provides this function.)

"Environmental systems contracting" (Abbr: EVS) is that service which provides for the installation, repair, improvement or removal of septic tanks and systems annexed to real property. (Note: The license classification of plumbing also provides for this function.)

"Equipment/machinery contracting" (Abbr: EMC) is that service which provides for the installation or removal of equipment or machinery from the customer's meter. (Note: No other license classification or specialty service provides for this function.)

"Farm improvement contracting" (Abbr: FIC) is that service which provides for the installation, repair or improvement of a nonresidential farm building or structure, or nonresidential farm accessory-use structure, or additions thereto. (Note: The building license classification also provides for this function.)

"Fire alarm-extinguishing systems contracting" (Abbr: FAE) is that service which provides for the installation, repair or improvement of fire alarm systems, fire extinguishing systems and fire alarm extinguishing systems annexed to real property. (Note: Excluding the installation of single-unit stand-alone smoke detectors, no other license classification or specialty service provides for this function.)

"Gas fitting contracting" (Abbr: GFC) is that service, performed by plumbing or HVAC contractors, which provides for the installation, repair or improvement of gas pipes and appliances annexed to real property. (Note: This function can only be performed in conjunction with the plumbing or HVAC license classification.)

"Home improvement contracting" (Abbr: HIC) is that service which provides for additions, repairs or improvements to residential buildings or structures or residential accessory-use structures. (Note: The building license classification also provides for this function.)

"Irrigation/sprinkler contracting" (Abbr: ISC) is that service which provides for the installation, repair, improvement or removal of irrigation systems or outdoor sprinkler systems. (Note: The plumbing license classification also provides for this function.)

"Landscape contracting" (Abbr: LSC) is that service which provides for the alteration or improvement of a land area by means of excavation, clearing, grading or other means of site preparation. (Note: The highway/heavy license classification also provides for this function.)

"Miscellaneous contracting" (Abbr: MSC) is that service which does not fall under any other license classification or specialty service. (Note: No other license classification or specialty service provides for this function.)

"Modular/mobile building contracting" (Abbr: MBC) is that service which provides for the installation or removal of a modular or mobile building. (Note: The building and highway/heavy license classifications also provide for this function.)

"Marine facility contracting" (Abbr: MCC) is that service which provides for the construction, repair, improvement or removal of any structure the purpose of which is to access, impede or alter a body of surface water. (Note: The highway/heavy license classification also provides for this function.

"Passive energy systems contracting" (Abbr: PES) is that service which provides for the installation, repair or

improvement, from the customer's meter, of passive energy generation systems or passive supplemental energy systems annexed to real property. (Note: No other license classification or specialty service provides this function.)

"Recreational facility contracting" (Abbr: RFC) is that service which provides for the construction, repair or improvement of any recreational facility, excluding the construction of buildings and paving. (Note: Excluding paving, the building license classification also provides for this function.)

"Striping/driveway contracting" (Abbr: SDC) is that service which provides for the striping of roadways or parking lots or the construction of limited access driveways. (Note: The highway/heavy license classification also provides for this function.)

"Vessel construction contracting" (Abbr: VCC) is that service which provides for the construction, repair or improvement of a nonresidential vessel to hold or convey fluid bodies. (Note: The highway/heavy license classification also provides for this function.

"Water well contracting" (Abbr: WWC) is that service which provides for the construction of a water well to reach groundwater as defined in § 62.1-44.85(8) of the Code of Virginia. (Note: No other license classification or specialty service provides for this function.)

Note: Specialty contractors engaging in construction which involves the following activities or items or similar activities or items may fall under the specialty service of commercial improvement, home improvement or farm improvement:

Awnings	*Marble*
Blinds	*Masonry*
Bricks	*Metal Work*
Bulkheads	*Millwrighting*
Cabinetry	*Mirrors*
Carpentry	*Miscellaneous Iron*
Carpeting	*Ornamental Iron*
Casework	*Painting*
Caulking	*Partitions*
Ceilings	*Plastic Wall Finishing*
Chimneys	*Protective Coatings*
Chutes	*Rigging*
Concrete	*Roofing*
Conduit Rodding	*Rubber Linings*
Curtains	*Railings*
Curtain Walls	*Sandblasting*
Decks	*Scaffolding*
Doors	*Screens*
Drapes	*Siding*
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Epoxy	*Shingles*
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Facings	*Skylights*
Fences	*Special Coatings*
Fiberglass	*Stone*
Fireplaces	*Storage Bins & Lockers*
Fireproofing	*Stucco*
Floors	*Temperature Controls*
Coverings	*Terrazzo*
Flooring	*Tile*
Glass	*Vaults*
Glazing	*Vinyl Flooring*
Grouting	*Waterproofing*
Grubbing	*Wall Coverings*
Guttering	*Wall Panels*
Illumination	*Wall Tile*
Insulation	*Weatherstripping*
Interior Decorating	*Welding*
Lighting	*Windows*
Lubrication	*Wood Floors*

PART II.
ENTRY.

§ 2.1. Requirements for licensure as a Class A sole proprietorship, partnership, association or corporation.

~~Every~~ *Each* sole proprietorship, *general* partnership, *limited partnership,* association or corporation seeking a Class A license shall complete an application furnished by the Department of Commerce and shall meet or exceed the requirements set forth below prior to issuance of the license.

A. Each ~~sole proprietorship, partnership, association or corporation~~ *applicant* shall have ~~in its full-time employ~~ a designated employee who is *a sole proprietor, partner of the general partnership, managing partner of the limited partnership, member of the association, officer of the corporation or an individual in the full-time employ of the firm, who is* at least 18 years of age and who has successfully completed or who has been deemed to have fulfilled the written or oral *licensure* examination required by the board.

B. The board, in its discretion, may deny *any application for* licensure ~~to any firm~~ in which the sole proprietor, officers of the corporation, ~~general~~ partners of the *general* partnership, *managing partners of the limited partnership,* members of the association, or designated employee have not maintained good standing in every jurisdiction where licensed as a contractor and shall not have had that license suspended, revoked or surrendered in connection with a disciplinary action in any jurisdiction within five years prior to applying for licensure in Virginia.

C. ~~Applicants~~ *Each applicant* will be required to provide information for the past five years including but not limited to outstanding past-due debts, judgments, outstanding state or federal tax obligations, and defaults on bonds. (Evidence of a pattern of failure to pay debts or noncompliance with contractual obligations sufficient to warrant the conclusion that the contracting business applying for a license is not likely to meet the financial responsibilities of a contractor shall be a basis for the denial of a license.)

D. ~~Applicants~~ *Each applicant* will be required to submit , on a form provided by the board, *information on the financial position of the contracting firm.* ~~a current balance sheet showing the assets, liabilities, and capital of the firm. A financial statement showing~~ *Excluding any jointly owned residence, each applicant will also be*

required to state a net worth ~~of less than~~ *or net equity of* $45,000 ~~for an individual ; partnership, or association, excluding any jointly owned residence, or a net equity of less than $45,000 for a corporation shall be a basis for the denial of a license~~ *or more* .

~~E. Applicants shall provide evidence acceptable to the board of five years experience in the license classification or specialty service for which licensure is sought. For license classifications or specialty services in which the board also requires an examination to demonstrate experience, the contractor shall have in the full-time employment of the firm seeking licensure an individual who has successfully completed an examination approved by the board.~~

E. Each applicant shall have in its full-time employ a qualified individual who is a sole proprietor, partner of the general partnership, managing partner of the limited partnership, member of the association, office of the corporation or an individual in the full-time employ of the firm, who is at least 18 years of age and who has five years experience in the license classification or specialty service sought by the firm. For license classifications or specialty services in which the board also requires an examination to demonstrate experience, the qualified individual for the firm shall have also successfully completed or been deemed to have fulfilled the trade-related examination approved by the board.

F. Any Class A contractor licensed in the Commonwealth of Virginia prior to January 1, 1991, and in business on December 31, 1990, shall , *within their current period of licensure,* provide to the board in writing the name of one full-time employee who is at least 18 years of age and that employee shall be deemed to have fulfilled the requirement for examination in § 2.1 of these regulations, so long as he remains a full-time employee of that contractor. Upon the departure of that employee, the contractor shall name another full-time employee in accordance with § 2.1 A. A fee shall be required for a declaration of a designated employee in accordance with § 2.5 D of these regulations.

G. The board, in its discretion, may deny licensure to any firm in which the sole proprietor, officers of the corporation, ~~general~~ partners of the *general* partnership, *managing partners of the limited partnership,* members of the association, or designated employee have been convicted in any jurisdiction of a misdemeanor involving lying, cheating or stealing; or of any felony. Any plea of nolo contendere shall be considered a conviction for the purposes of this subsection. 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.

§ 2.2. Requirements for licensure as a Class B sole proprietorship, partnership, association or corporation.

~~Every~~ *Each* sole proprietorship, *general* partnership, *limited partnership,* association or corporation seeking a Class B license shall complete an application furnished by the Department of Commerce and shall meet or exceed the requirements set forth below prior to issuance of the license.

A. Each ~~sole proprietorship, partnership, association or corporation~~ *applicant* shall have ~~in its full-time employ~~ a designated employee who is *a sole proprietor, partner of the general partnership, managing partner of the limited partnership, member of the association, officer of the corporation or an individual in the full-time employ of the firm, who is* at least 18 years of age and who has successfully completed or who has been deemed to have fulfilled the written or oral *licensure* examination required by the board.

B. The board, in its discretion, may deny *any application for* licensure ~~to any firm~~ in which the sole proprietor, officers of the corporation, ~~general~~ partners of the *general* partnership, *managing partners of the limited partnerships,* members of the association, or designated employee have not maintained good standing as a licensed contracting business in every jurisdiction where licensed as a contractor and shall not have had that license as a contracting business suspended, revoked or surrendered in connection with a disciplinary action in any jurisdiction within five years prior to applying for licensure in Virginia.

C. ~~Applicants~~ *Each applicant* will be required to provide information for the past three years including but not limited to outstanding past-due debts, judgments, outstanding state or federal tax obligations, and defaults on bonds. (Evidence of a pattern of failure to pay debts or noncompliance with contractual obligations sufficient to warrant the conclusion that the contracting business applying for a license is not likely to meet the financial responsibilities of a contractor shall be a basis for the denial of a license.)

D. ~~Applicants~~ *Each applicant* ~~who were not registered in the Commonwealth of Virginia prior to January 1, 1991, and in business on December 31, 1990,~~ will be required to submit , on a form provided by the board, *information on the financial position of the contracting firm.* ~~a current balance sheet showing the assets, liabilities, and capital of the firm. A financial statement showing a net worth of less than $15,000 for an individual , partnership, or association, excluding any jointly owned residence, or a net equity of less than $20,000 $15,000 for a corporation shall be a basis for the denial of a license.~~

~~E. Applicants shall provide evidence acceptable to the board of three years experience in the license classification or specialty service for which licensure is sought. For license classifications or specialty services in which the board also requires an examination to demonstrate experience, the contractor shall have in the full-time employment of the firm seeking licensure an individual who has successfully completed an examination~~

~~approved~~ ~~by~~ ~~the~~ ~~board.~~ *Each applicant shall have in its full-time employ a qualified individual who is a sole proprietor, partner of the general partnership, managing partner of the limited partnership, member of the association, officer of the corporation or an individual in the full-time employ of the firm, who is at least 18 years of age and who has three years experience in the license classification or specialty service sought by the firm. For license classifications or specialty services in which the board also requires an examination to demonstrate experience, the qualified individual for the firm shall have also successfully completed or been deemed to have fulfilled the trade-related examination approved by the board.*

F. Any Class B contractor registered in the Commonwealth of Virginia prior to January 1, 1991, and in business on December 31, 1990, shall , *within their registration period,* provide to the board in writing the name of one full-time employee who is at least 18 years of age and that employee shall be deemed to have fulfilled the requirement for examination in § 2.2 of these regulations, so long as he remains a full-time employee of that contractor. Upon the departure of that designated employee, the contractor shall name another full-time employee in accordance with § 2.2 A. A fee shall be required for a declaration of a designated employee in accordance with § 2.5 D of these regulations.

G. The board, in its discretion, may deny licensure to any firm in which the sole proprietor, officers of the corporation, ~~general~~ partners of the *general* partnership, *managing partners of the limited partnership,* members of the association, or designated employee have been convicted in any jurisdiction of a misdemeanor involving lying, cheating or stealing; or of any felony. Any plea of nolo contendere shall be considered a conviction for the purposes of this subsection. 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.

§ 2.3. Examination requirements.

A. The designated employee for a Class A firm, except as provided in § 2.1 F, shall attain a passing grade established by the board on ~~an~~ *a licensure* examination the subject of which shall be the regulations and statutes of the board and on the general knowledge necessary to engage in the administrative and business activities of the Class A firm. The Class A *licensure* examination shall consist of the Virginia section, General section, and Advanced section. The Virginia section will test the candidate's knowledge of statutory and regulatory requirements. The General section will test the candidate's general administrative and business knowledge necessary to engage in contracting activities. The Advanced section will test the candidate's general administrative and business knowledge necessary to engage in Class A contracting activities.

B. The designated employee for a Class B firm, except as provided in § 2.2 F, shall attain a passing grade established by the board on ~~an~~ *a licensure* examination the subject of which shall be the regulations and statutes of the board and on the general knowledge necessary to engage in the administrative and business activities of the Class B firm. The Class B *licensure* examination shall consist of the Virginia section and General section. The Virginia section will test the candidate's knowledge of statutory and regulatory requirements. The General section will test the candidate's general administrative and business knowledge necessary to engage in contracting activities.

C. *Licensure* examinations ~~for designated employees~~ which are required by the board shall be approved by the board and provided by the board or by a testing service acting on behalf of the board. *(Note: An individual fulfilling the licensure examination requirement for a contracting firm is referred to as a designated employee.)*

D. *Trade-related* examinations *which are also* required by the board to demonstrate experience for a license classification or specialty service shall be approved by the board. *(Note: An individual fulfilling a trade-related examination requirement for a contracting firm must also serve as a firm's qualified individual.)*

§ 2.4. License by reciprocity.

A. Applicants for Class A licensure by reciprocity shall meet the requirements set forth in § 2.1 of these regulations. A designated employee, for the firm seeking reciprocal licensure, who has passed in the jurisdiction of original licensure an examination deemed to be substantially equivalent to the *licensure* examination required by the board shall only be required to successfully complete the Virginia section and when deemed necessary the Advanced section of the *licensure* examination. *A qualified individual for the firm seeking reciprocal licensure who has passed in the jurisdiction of original licensure an examination deemed to be substantially equivalent to a trade-related examination required by the board shall be deemed to have fulfilled the trade-related examination requirement.*

B. Applicants for Class B licensure by reciprocity shall meet the requirements set forth in § 2.2 of these regulations. A designated employee, for the firm seeking reciprocal licensure, who has passed in the jurisdiction of original licensure an examination deemed to be substantially equivalent to the *licensure* examination required by the board shall only be required to successfully complete the Virginia section of the *licensure* examination. *A qualified individual for the firm seeking reciprocal licensure who has passed in the jurisdiction of original licensure an examination deemed to be substantially equivalent to a trade-related examination required by the board shall be deemed to have fulfilled the trade-related examination requirement.*

~~C. Applicants for Class A and Class B licensure by reciprocity shall provide evidence acceptable to the board of experience in the license classification or specialty service for which licensure is sought.~~

~~D.~~ *C.* No license shall be issued to an applicant whose previous license/registration has been suspended for nonpayment of a Virginia Contractor Transaction Recovery Fund assessment until all past-due assessments have been paid.

§ 2.5. Fees for licensing, designated employee declaration, and examination.

A. Fee payments.

Each check or money order shall be made payable to the Treasurer of Virginia. All fees required by the board are nonrefundable.

B. Class A original license fee.

The fee for an initial Class A license shall be $85.

C. Class B original license fee.

The fee for an initial Class B license shall be $65.

~~D. Class A designated employee declaration fee.~~

~~The fee for declaring a designated employee for Class A licensure shall be $25.~~

~~E.~~ *D.* ~~Class B~~ Designated employee declaration fee.

The fee for declaring a designated employee for Class *A or* B licensure shall be $25.

~~F.~~ *E.* Class A *licensure* examination fee.

The fee for a Class A *licensure* examination shall be $60 The fee for an examination in any individual section of the Class A *licensure* examination package shall be $20 for the Virginia section, $20 for the General section, and $20 for the Advanced section. Individuals who successfully complete one or more but not all of the sections upon initial examination shall have 12 months from the date of that initial examination to successfully complete the remaining sections of the Class A examination package.

~~G.~~ *F.* Class B *licensure* examination fee.

The fee for a Class B *licensure* examination shall be $40 The fee for an examination in any individual section of the Class B *licensure* examination package shall be $20 for the Virginia section and $20 for the General section. Individuals who successfully complete only one section upon initial examination shall have 12 months from the date of that initial examination to successfully complete the remaining section of the Class B examination package.

~~H.~~ *G.* Class A reciprocity *licensure* examination ~~fee~~ *fees* .

The fee for a Class A reciprocity *licensure* examination shall be $20 for individuals required to take the Virginia section of the Class A *licensure* examination package and $40 for individuals required to take both the Virginia section and Advanced section of the Class A *licensure* examination package.

~~I.~~ *H.* Class B reciprocity *licensure* examination fee.

The fee for a Class B reciprocity *licensure* examination shall be $20 for individuals required to take the Virginia section of the Class B *licensure* examination package.

~~J.~~ *I.* Upgrade *licensure* examination ~~fee~~ *fees* .

~~The fee for a Class B to Class A upgrade examination shall be $20 for the Advanced section of the Class A examination package.~~ *The fee for the Advanced section of the licensure examination shall be $20 when a designated employee for a Class B contractor seeks to successfully complete the Class A licensure examination requirement.*

~~K.~~ *J.* License classification or specialty service *trade-related* examination fee.

The fee for ~~an~~ *a trade-related* examination, when offered by the board, in any of the license classifications or specialty services shall *not* be ~~$150~~ *more than $100* .

PART III.
RENEWAL AND REINSTATEMENT

§ 3.1. Renewal.

All Class A and Class B licensees wishing to renew their licenses must apply for license renewal every two years. After January 1, 1991, Class B registrations are not renewable in accordance with § 54.1-1108.1 of the Code of Virginia.

A. Fees.

The application fee for renewal of a Class A license is $65 and the application fee for renewal of a Class B license is $45. All fees required by the board are nonrefundable.

B. Procedures.

The Department of Commerce will mail a renewal notice to the licensee outlining procedures for renewal. Failure to receive this notice, however, shall not relieve the licensee of the obligation to renew. If the licensee fails to receive the renewal notice, a copy of the license may be submitted with the required fee as an application for renewal *within 30 days of the expiration date of the license* .

C. Applicants for renewal of a license (expiring on or after January 31, 1991) shall certify on a form provided by the board that they meet the current standards for entry as follows:

1. Those applying for renewal of a Class A license shall meet the requirements of §§ 2.1 A, 2.1 B, 2.1 G, and, where applicable, § 2.1 E.

2. Those applying for renewal of a Class B license shall meet the requirements of §§ 2.2 A, 2.2 B, 2.2 G, and, where applicable, § 2.2 E.

D. The date on which the renewal fee is received by the department or its agent will determine whether the licensee is eligible for renewal or required to apply for reinstatement.

§ 3.2. Reinstatement.

Any licensee failing to apply for renewal of its license within 30 days of its expiration date will be required to reinstate the license.

A. Fees.

The application fee for reinstatement of a Class A license is $75 and the application fee for reinstatement of a Class B license is $60. All fees required by the board are nonrefundable.

B. Applicants for reinstatement shall meet the requirements of § 3.1 of these regulations.

C. The date on which the reinstatement fee is received by the Department of Commerce or its agent will determine whether the license is reinstated or a new application for licensure is required.

D. In order to ensure that licensees are qualified to practice as contractors, no reinstatement will be permitted once six months from the expiration date of the license has passed. After that date the applicant must apply for a new license and meet the then current entry requirements.

§ 3.3. Board discretion to deny renewal or reinstatement.

The board may deny renewal or reinstatement of a license for the same reasons as it may refuse initial licensure or discipline a licensee.

PART IV.
STANDARDS OF PRACTICE.

§ 4.1. ~~Change~~ ~~in~~ Management personnel.

A. Reporting of Management Personnel.

Class A licensees and Class B licensees/registrants shall report in writing or on a form provided by the board ~~any changes in~~ the following personnel:

The sole proprietor;

~~The general~~ Partners *of a general partnership* ;

Managing partners of a limited partnership;

Members of an association;

Officers of the corporation;

Designated employee;

~~Individual qualified in a license classification or specialty service~~ *Qualified individual* .

B. Changes in management personnel.

~~This information must be provided to the board~~ *Should any change occur in the management personnel, the licensee/registrant is required to report those changes to the board* within 90 days of the change. *A change in management personnel shall be reported as follows:*

1. When there is a change in the sole proprietor, the partners of a general partnership, managing partners of a limited partnership, or members of an association, the licensee/registrant will report those changes in a signed statement to the board. (A change in the sole proprietor, the partners of a general partnership, managing partners of a limited partnership, or members of an association will result in the termination of the license/registration.)

2. When there is a change in the officers of the corporation, the licensee/registrant shall report the changes in a signed statement to the board.

3. When there is a change in the designated employee, the licensee shall declare, on a form approved by the board, a new designated employee. New designated employees shall be declared as follows:

a. Individuals declared as designated employees for Class A firms shall meet the requirements of § 2.1 A, § 2.3 A or §§ 2.4 A and 2.5 D.

b. Individuals declared as designated employees for Class B firms shall meet the requirement of § 2.1 B, § 2.3 B, or §§ 2.4 B and 2.5 D.

4. When there is a change in a qualified individual, the licensee shall report, on a form provided by the board, a new qualified individual. New qualified individuals shall be reported as follows:

a. Individuals reported as qualified individuals for Class A firms shall meet the requirements of § 2.1 E.

b. Individuals reported as qualified individuals for

Class B firms shall meet the requirements of § 2.2 E.

C. Status of license due to changes in the officers of a corporation, designated employee, or qualified individuals.

In the event that a reported change of personnel affects the status of the contracting firm's license/registration the board shall promptly notify the ~~Class A licensed firm and Class B licensed/registered~~ firm in writing that the continuation of the firm's license/registration has been *deferred for the board's review and consideration. Subsequent to the board's consideration, the firm will further be notified in writing that its license/registration has been* granted or denied in accordance with ~~the requirements of §§ 2.1 A, 2.1 E, and 2.1 G for Class A licensees; §§ 2.2 A, 2.2 E, and 2.2 G for Class B licensees; and § 2.2 G for Class B registrants~~ *these regulations* .

D. Restrictions for designated employees and qualified individuals.

Designated employees and qualified individuals are required to be in the full-time employ of the contracting firm, which means they may not, as designated employees or qualified individuals, represent more than two firms at one time unless they also serve as the sole proprietor, partner in the general partnership, managing partner in limited partnership, member of the association, or officer of the corporation for those same contracting firms.

§ 4.2. ~~Name changes~~ *Firm names* .

A licensee/registrant must operate under the name in which the license/registration is issued. As long as there is no change in the legal entity, a licensee/registrant may secure a name change by submitting a written request to the board for such a change. The request must show the name as it then appears on the license/registration and the new name, and must be accompanied by a Certificate of Amendment from the State Corporation Commission if the licensee/registrant is a corporation, or authorization from the appropriate local court, if a licensee/registrant other than a corporation is trading under a fictitious name.

§ 4.3. Changes, additions, or deletions to license classifications or specialty services

A licensee may change a license classification or specialty service or obtain additional license classifications or specialty services by ~~providing~~ *demonstrating, on a form provided by the board, acceptable* evidence ~~acceptable to the board~~ of experience in ~~that~~ *the* license ~~classification~~ *classifications* or specialty ~~service~~ *services sought* . ~~When the board also requires an examination to demonstrate experience in a license classification or specialty service, acceptable evidence can be demonstrated by certifying on a form provided by the Department of Commerce the full-time employment of an individual who has successfully completed the appropriate examination for the license classification or specialty service sought.~~ *The experience necessary for a Class A firm may be demonstrated by meeting the requirements of § 2.1 E. The experience necessary for a Class B firm may be demonstrated by meeting the requirements of § 2.2 E.* The fee for each change or addition is $25. All fees required by the board are nonrefundable. *If a licensee is seeking to delete a license classification or specialty service, then it shall provide a signed statement listing the license classifications or specialty services to be deleted. There is no fee for the deletion of a license classification or specialty service. (If the licensee only has one license classification or specialty service, the deletion of that classification or service will result in the termination of the license.)*

§ 4.4. Change of address.

Licensees/registrants shall report any change of address to the board in writing within 30 days of the change.

§ 4.5. Transfer of license/registration prohibited.

No license/registration issued by the board shall be assigned or otherwise transferred. Licenses/registrations are issued to the legal business entities whether they be proprietorships, *general* partnerships, *limited partnerships, associations, or* corporations ~~; joint ventures or other legal entities~~ . Whenever there is any change in the ownership of a sole proprietorship, *general* partnership, or association, a new license is required. Also, whenever *the managing partners of a limited partnership change or when* a corporation is dissolved and a new corporation formed, a new license is required.

PART V.
STANDARDS OF CONDUCT.

§ 5.1. ~~Prohibited acts~~ *Filing of charges* .

A. All complaints against contractors, excluding complaints by utilities involving violations of the Underground Utility Damage Prevention Act, may be filed with the Department of Commerce at any time during business hours, pursuant to § 54.1-1114 of the Code of Virginia.

B. A utility may file a report with the Department of Commerce, pursuant to § 54.1-1114 of the Code of Virginia, listing all contractors who have caused damage to the utility's lines more than 10 times in the preceding year, as a result of a failure to comply with the Underground Utility Damage Prevention Act (§ 56-265.14 et seq.). The report shall list each contractor separately and shall contain a precise explanation of each incident involving damage to the utility's lines. The report shall further contain all documentation supporting the complaint, which is available to the utility. The report shall contain the utility's certification that it has exhausted its available civil remedies or does not intend to seek such civil remedies. Each contractor listed in the

report must be notified by the utility, in writing, of the pending charges prior to issuance of the report. The utility will further include with its notification to the contractor a written statement providing that the contractor has the right to contact the Department of Commerce and respond to the allegations contained in the report.

C. A utility may file a complaint with the Department of Commerce, pursuant to § 54.1-1114 of the Code of Virginia, when a contractor has failed to properly notify Miss Utility prior to excavation.

§ 5.2. Prohibited acts.

The following are cause for disciplinary action:

1. Failure in any material way to comply with provisions of Chapter 1 or Chapter 11 of Title 54.1 of the Code of Virginia or the regulations of the board.

2. Furnishing substantially inaccurate or incomplete information to the board in obtaining, renewing, reinstating, or maintaining a license.

3. Where the sole proprietor, officer of the corporation, partner in the partnership, members of the association, or designated employee have failed to report to the board, in writing, the suspension or revocation of a contractor license by another state or his conviction in a court of competent jurisdiction of a building code violation.

4. Publishing or causing to be published any advertisement relating to contracting which contains an assertion, representation, or statement of fact that is false, deceptive, or misleading.

5. ~~Gross~~ Negligence, or continued incompetence, or misconduct in the practice of his profession.

6. A finding of improper or dishonest conduct in the practice of his profession by a court of competent jurisdiction.

~~6.~~ *7.* Failure of all those who engage in residential contracting, excluding subcontractors to the contracting parties and those who engage in routine maintenance or service contracts, to make use of a legible written contract clearly specifying the terms and conditions of the work to be performed. For the purposes of these regulations, residential contracting means construction, removal, repair, or improvements to single-family or multiple-family residential buildings, including accessory-use structures. Prior to commencement of work or acceptance of payments, the contract shall be signed by both the consumer and the licensee/registrant or his agent. At a minimum the contract shall specify or disclose the following:

a. When work is to begin and the estimated completion date;

b. A statement of the total cost of the contract and the amounts and schedule for progress payments including a specific statement on the amount of the down payment;

c. A listing of ~~specified~~ materials and work to be performed , *which is specifically requested by the consumer* ;

d. A "plain-language" exculpatory clause concerning events beyond the control of the contractor and a statement explaining that delays caused by such events do not constitute abandonment and are not included in calculating time frames for payment or performance;

e. A statement of assurance that the contractor will comply with all local requirements for building permits, inspections, and zoning;

f. Disclosure of the cancellation rights of the parties;

g. ~~A~~ *For contracts resulting from a door to door solicitation, a* signed acknowledgement by the consumer that he has been provided with and read the Department of Commerce statement of protections available to him through the Board ~~of~~ *for* Contractors;

h. Contractor's name, address, license/registration number, expiration date, class of license/registration, and license classifications or specialty services;

i. Statement providing that any modification to the contract, which changes the cost, materials, work to be performed, or estimated completion date, must be in writing and signed by all parties.

~~7.~~ *8.* Failure to make prompt delivery to the consumer before commencement of work of a fully executed copy of the contract as described in subdivision ~~6~~ *7* of this section for construction or contracting work.

~~8.~~ *9.* Failure of the contractor to maintain for a period of three years from the date of contract a complete and legible copy of all documents relating to that contract, including, but not limited to, the contract and any addenda or change orders.

~~9.~~ *10.* Refusing or failing, upon request or demand, to produce to the board, or any of its agents, any document, book, record or copy thereof in the licensee's/registrant's possession concerning a transaction covered by these regulations or for which the licensee/registrant is required to maintain records, or failing to cooperate in the investigation of a complaint filed with the board against the contractor.

~~10.~~ *11.* Abandonment, or the intentional and unjustified

failure to complete work contracted for, or the retention or misapplication of funds paid, for which work is either not performed or performed only in part. (Unjustified cessation of work under the contract for a period of 30 days or more shall be considered evidence of abandonment.)

~~11.~~ *12.* Making any misrepresentation or making a false promise of a character likely to influence, persuade, or induce.

~~12.~~ *13.* Aiding or abetting an unlicensed/unregistered contractor to violate any provision of Chapter 1 or Chapter 11 of Title 54.1 of the Code of Virginia, or these regulations; or combining or conspiring with or acting as agent, partner, or associate for an unlicensed/unregistered contractor; or allowing a firm's license/registration to be used by an unlicensed/unregistered contractor; or acting as or being an ostensible licensee/registrant for undisclosed persons who do or will control or direct, directly or indirectly, the operations of the licensee's/registrant's business.

~~13.~~ *14.* Where the sole proprietor, officers of the corporation, general partners in the partnership, members of the association, or designated employee have offered, given or promised anything of value or benefit to any federal, state, or local employee for the purpose of influencing that employee to circumvent, in the performance of his duties, any federal, state, or local law, regulation, or ordinance governing the construction industry.

~~14.~~ *15. Where the firm, sole proprietor, partners in the general partnership, managing partners in the limited partnership, member of the association, officers of the corporation or designed employee* have been convicted or found guilty, *after initial licensure,* regardless of adjudication, in any jurisdiction of any felony or of a misdemeanor involving lying, cheating or stealing, there being no appeal pending therefrom or the time of appeal having elapsed. Any plea of guilty or nolo contendere shall be considered a conviction for the purposes of this subdivision. The record of a conviction certified or 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 guilt.

~~15.~~ *16.* ~~Failing~~ *Having failed* to inform the board in writing within 30 days *that the firm or its sole proprietor or one of its partners in the general partnership, managing partners in the limited partnership, member of the association, officers of the corporation or that its designated employee* ~~of pleading~~ *has pleaded* guilty or nolo contendere or ~~of being~~ *was* convicted and found guilty of any felony or of a misdemeanor involving lying, cheating or stealing.

~~16.~~ *17.* ~~Have~~ *Having* been disciplined by any county, city, town, or any state or federal governing body, which action shall be reviewed by the board before it takes any disciplinary action of its own.

~~17.~~ *18.* Failure to comply with the Virginia Uniform Statewide Building Code , *as amended* .

19. Failure of all contractors who excavate to adopt a prominently displayed written policy which includes the following:

a. A statement that it is the firm's policy to prevent damage to underground utility lines while engaging in the activities of a "Contractor," as defined in § 54.1-1100 of the Code of Virginia;

b. A statement that it is the firm's policy to advise the designated representatives of all affected utility companies, or Miss Utility, of the location of any proposed excavations at least 48 hours, excluding Saturdays, Sundays and holidays, prior to excavation;

c. A statement that is is the firm's policy to notify the designated representatives of all affected utility companies, or Miss Utility, of a proposed excavation and provide such information as the utility company requires under the Underground Utility Prevention Act.

d. A statement that it is the firm's policy to take all reasonable steps to protect buried utility lines and that such protection shall include steps to ensure that the lines are protected while exposed;

e. A statement that it is the firm's policy to report any damages to utility lines to the affected utility companies and the responsible public safety officials;

f. A statement that it is the firm's policy to inform all its employees who supervise excavations of this section of the regulations.

20. Failure of a contractor to notify Miss Utility prior to excavation.

21. Practicing in a license classification or specialty service for which the contractor is not licensed.

NOTICE: The forms used in administering the Regulations of the Board for Contractors 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 Commerce, 3600 West Broad Street, Richmond, Virginia, or at the Office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Room 262, Richmond, Virginia.

Contractors License Application Form (RBC-4, 07-01-92)

Contractors Class A Renewal Application Form (RBC-12, 07-01-92)
Contractors Class A Reinstatement Application Form (RBC-10, 07-01-92)
Class B Registration to License Application Form (RBC-11, 07-01-92)
Contractors Designated Employee Declaration Application Form, (RBC-5, 07-01-92)
Contractors License Classification or Specialty Service Addition Application Form (RBC-14, 07-01-92)
Contractors Qualified Individual Change Application Form (RBC-4, 07-01-92)
Bank Reference Form (SBC:B, 01-01-92)
Credit Reference Form (SBC:G, 01-01-92)
Experience Reference Form (SBC:G, 01-01-92)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

Title of Regulation: **State Plan for Medical Assistance Relating to Inpatient Hospital Settlement Agreement. VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care.**

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

Public Hearing Date: N/A – Written Comments may be submitted until April 10, 1992.
(See Calendar of Events section for additional information)

Summary:

This regulation will implement the requirements of the Final Settlement Agreement between the Commonwealth and the VHA.

This regulation amends the Methods and Standards for establishing payment rates, effective July 1, 1992, for inpatient hospital care services (attachment 4.19A) by establishing a Payment Adjustment Fund and by adding an additional two percentage points (200 basis points) to DMAS' prescribed inflation allowance used to calculate the prospective operating cost rate and prospective operating cost ceiling for hospitals subject to the prospective payment system of reimbursement (PPS).

In July 1982, DMAS implemented the PPS for hospitals. In March 1986, the VHA, on behalf of its member hospitals, filed suit against DMAS, challenging the Department's methodology for establishing rates for inpatient hospital services as required by the Medicaid Act (Section 1902(a) of the Social Security Act). The VHA alleged that Medicaid payments were inadequate and estimated that its member hospitals would suffer losses of $51.3 million in FY 90 as a result. The Commonwealth denied the VHA allegations and vigorously asserted its compliance with the Medicaid Act.

In December 1990, after five years of litigation, the Commonwealth and VHA agreed to an out-of-court settlement, which left DMAS' inpatient hospital reimbursement methodology intact. The agreement further provided for a Payment Adjustment Fund (PAF) in each of the Commonwealth's fiscal years during the period July 1, 1992, to June 30, 1996. The PAF is to consist of the Commonwealth's cumulative addition of $5 million in general funds along with corresponding federal financial participation for reimbursement to nonstate-owned hospitals in each of the Commonwealth's fiscal years during the period.

Additionally, the agreement provided, effective July 1, 1992, for the prescribed allowance for inflation (the HCFA-type Hospital Basket, adjusted for Virginia, as developed by Data Resources, Inc. (DRI-V)), to be converted to an escalation factor by adding two percentage points (200 basis points) to the then current DRI-V.

VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care.

The state agency will pay the reasonable cost of inpatient hospital services provided under the Plan. In reimbursing hospitals for the cost of inpatient hospital services provided to recipients of medical assistance.

I. For each hospital also participating in the Health Insurance for the Aged Program under Title XVIII of the Social Security Act, the state agency will apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the inpatient routine services costs for medical assistance recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII inpatient routing service charges or patient days as well as Title XVIII inpatient routine service cost.

II. For each hospital not participating in the Program under Title XVIII of the Act, the state agency will apply the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost apportionment methods in 42 CFR 447.250, or (b) the "Gross RCCAC method" of cost apportionment applied as follows: For a reporting period, the total allowable hospital inpatient charges; the resulting percentage is applied to the bill of each inpatient under the Medical Assistance Program.

III. For either participating or nonparticipating facilities, the Medical Assistance Program will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2), and/or lesser of reasonable cost or customary charges in 42 CFR 447.250.

IV. The state agency will apply the standards and principles as described in the state's reimbursement plan approved by the Secretary, HHS on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in paragraphs I and II above.

V. The reimbursement system for hospitals includes the following components:

(1) Hospitals were grouped by classes according to number of beds and urban versus rural. (Three groupings for rural–0 to 100 beds, 101 to 170 beds, and over 170 beds; four groupings for urban–0 to 100, 101 to 400, 401 to 600, and over 600 beds.) Groupings are similar to those used by the Health Care Financing Administration (HCFA) in determining routine cost limitations.

(2) Prospective reimbursement ceilings on allowable operating costs were established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982, were subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, was based on available, allowable cost data for all hospitals in calendar year 1981. Individual hospital operating costs were advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs were standardized using SMSA wage indices, and a median was determined for each group. These medians were readjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping has a series of ceilings representing one of each SMSA area. The wage index is based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

Effective July 1, 1986, and until June 30, 1988, providers subject to the prospective payment system of reimbursement had their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This method uses an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Chase Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year began.

The prospective operating cost rate is based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

The prospective operating cost ceiling is determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The allowance for inflation percent of change for the quarter in which the provider's new fiscal year began is added to this base to determine the new operating cost ceiling. This new ceiling was effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the base for computing the next prospective year ceiling.

Effective on and after July 1, 1988, and until June 30, 1989, for providers subject to the prospective payment system, the allowance for inflation ~~will~~ *shall* be based on the percent of change in the moving average of the Data Resources, Incorporated Health Care Cost HCFA-Type Hospital Market Basket determined in the quarter in which the provider's new fiscal year begins. Such providers ~~will~~ *shall* have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1988, for all such hospitals ~~will~~ *shall* be adjusted to reflect this change.

Effective on and after July 1, 1989, for providers subject to the prospective payment system, the allowance for inflation ~~will~~ *shall* be based on the percent of change in the moving average of the Health Care Cost HCFA-Type Hospital Market Basket, adjusted for Virginia *(DRI-V)* , as developed by Data Resources, Incorporated, determined in the quarter in which the provider's new fiscal year begins. Such providers ~~will~~ *shall* have their prospective operating cost rate and prospective operating cost ceiling established in accordance with the methodology which became effective July 1, 1986. Rates and ceilings in effect July 1, 1989, for all such hospitals ~~will~~ *shall* be adjusted to reflect this change.

Effective on and after July 1, 1992, for providers subject to the prospective payment system, the allowance for inflation, as described above, which became effective on July 1, 1989, shall be converted to an escalation factor by adding two percentage points (200 basis points) (DRI-V+2), to the then current allowance for inflation. The escalation factor shall be applied in accordance with the current inpatient hospital reimbursement methodology. On July 1, 1992, the conversion to the new escalation factor shall be accomplished by a transition methodology which, for non-June 30 year end hospitals, applies the escalation factor to escalate their payment rates for the months between July 1, 1992, and their next fiscal year ending on or before May 31, 1993.

The new method ~~will~~ *shall* still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

(3) Subsequent to June 30, 1982, the group ceilings ~~should~~ *shall* not be recalculated on allowable costs,

but ~~should~~ *shall* be updated by the escalator.

(4) Prospective rates for each hospital ~~should~~ *shall* be based upon the hospital's allowable costs plus the escalator, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment ~~should~~ *shall* be made to prospective rates.

Depreciation, capital interest, and education costs approved pursuant to ~~HIM~~ *PRM* -15 (Sec. 400), ~~should~~ *shall* be considered as pass throughs and not part of the calculation.

(5) An incentive plan ~~should~~ *shall* be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 25% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive ~~should~~ *shall* be calculated based on the annual cost report.

The table below presents three examples under the new plan:

Group Ceiling	Hospital's Allowable Cost Per Day	Difference $	% of Ceiling	Sliding Scale Incentive $	% of Difference
$230	$230	0	0	0	0
$230	207	23.00	10%	2.30	10%
$230	172	57.50	25%	14.38	25%
$230	143	76.00	33%	19.00	25%

(6) There ~~will~~ *shall* be special consideration for exception to the median operating cost limits in those instances where extensive neonatal care is provided.

(7) Hospitals which have a disproportionately higher level of Medicaid patients and which exceed the ceiling shall be allowed a higher ceiling based on the individual hospital's Medicaid utilization. This shall be measured by the percent of Medicaid patient days to total hospital patient days. Each hospital with a Medicaid utilization of over 8.0% shall receive an adjustment to its ceiling. The adjustment shall be set at a percent added to the ceiling for each percent of utilization up to 30%.

Disproportionate share hospitals defined.

Effective July 1, 1988,[1] the following criteria shall be met before a hospital is determined to be eligible for a disproportionate share payment adjustment.

A. Criteria.

1. A Medicaid inpatient utilization rate in excess of 8.0% for hospitals receiving Medicaid payments in the Commonwealth, or a low-income patient utilization rate exceeding 25% (as defined in the Omnibus Budget Reconciliation Act of 1987 and as amended by the Medicare Catastrophic Coverage Act of 1988); and

2. At least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

3. Subsection A 2 does not apply to a hospital:

a. At which the inpatients are predominantly individuals under 18 years of age; or

b. Which does not offer nonemergency obstetric services as of December 21, 1987.

B. Payment adjustment.

1. Hospitals which have a disproportionately higher level of Medicaid patients shall be allowed a disproportionate share payment adjustment based on the individual hospital's Medicaid utilization. The Medicaid utilization shall be determined by dividing the total number of Medicaid inpatient days by the number of inpatient days. Each hospital with a Medicaid utilization of over 8.0% shall receive a disproportionate share payment adjustment. The disproportionate share payment adjustment shall be equal to the product of (i) the hospital's Medicaid utilization in excess of 8.0%, times (ii) the lower of the prospective operating cost rate or ceiling.

2. A payment adjustment for hospitals meeting the eligibility criteria in subsection A above and calculated under subsection B 1 above shall be phased in over a 3-year period. As of July 1, 1988,[2] the adjustment shall be at least one-third the amount of the full payment adjustment; as of July 1, 1989, the payment shall be at least two-thirds the full payment adjustment; and as of July 1, 1990, the payment shall be the full amount of the payment adjustment. However, for each year of the phase-in period, no hospital shall receive a disproportionate share payment adjustment which is less than it would have received if the payment had been calculated pursuant to § V (5) of Attachment 4.19A to the State Plan in effect before July 1, 1988.

(8) DMAS shall pay to disproportionate share hospitals (as defined in § V (7) above) an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs for individuals under one year of age. The adjustment shall be calculated as follows:

(a) Each eligible hospital which desires to be

considered for the adjustment shall submit a log which contains the information necessary to compute the mean of its Medicaid per diem operating cost of treating individuals under one year of age. This log shall contain all Medicaid claims for such individuals, including, but not limited to: (i) the patient's name and Medicaid identification number; (ii) dates of service; (iii) the remittance date paid; (iv) the number of covered days; and (v) total charges for the length of stay. Each hospital shall then calculate the per diem operating cost (which excludes capital and education) of treating such patients by multiplying the charge for each patient by the Medicaid operating cost-to-charge ratio determined from its annual cost report.

(b) Each eligible hospital shall calculate the mean of its Medicaid per diem operating cost of treating individuals under one year of age. Any hospital which qualifies for the extensive neonatal care provision (as governed by § V (6) above) shall calculate a separate mean for the cost of providing extensive neonatal care to individuals under one year of age.

(c) Each eligible hospital shall calculate its threshold for payment of the adjustment, at a level equal to two and one-half standard deviations above the mean or means calculated in subdivision (b) above.

(d) DMAS shall pay as an outlier adjustment to each eligible hospital all per diem operating costs which exceed the applicable threshold or thresholds for that hospital.

Pursuant to section 1 of Supplement 1 to Attachment 3.1 A and B, there is no limit on length of time for medically necessary stays for individuals under one year of age.

VI. In accordance with Title 42 §§ 447.250 through 447.272 of the Code of Federal Regulations which implements § 1902(a)(13)(A) of the Social Security Act, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that shall be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards. To establish these rates Virginia uses the Medicare principles of cost reimbursement in determining the allowable costs for Virginia's prospective payment system. Allowable costs will be determined from the filing of a uniform cost report by participating providers. The 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, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has 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), a statement of changes in financial position, and footnotes to the financial statements;

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

5. Home office cost report, if applicable; and

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

Although utilizing the cost apportionment and cost finding methods of the Medicare Program, Virginia does not adopt the prospective payment system of the Medicare Program enacted October 1, 1983.

VII. Revaluation of assets.

A. Effective October 1, 1984, the valuation of an asset of a hospital or long-term care facility which has undergone a change of ownership on or after July 18, 1984, shall be the lesser of the allowable acquisition cost to the owner of record as of July 18, 1984, or the acquisition cost to the new owner.

B. In the case of an asset not in existence as of July 18, 1984, the valuation of an asset of a hospital or long-term care facility shall be the lesser of the first owner of record, or the acquisition cost to the new owner.

C. In establishing an appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable prior to July 1, 1986) the base to be used for such computations shall be limited to A or B above.

D. Costs (including legal fees, accounting and administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) shall be reimbursable only to the extent that they have not been previously reimbursed by Medicaid.

E. The recapture of depreciation up to the full value of the asset is required.

F. Rental charges in sale and leaseback agreements shall be restricted to the depreciation, mortgage interest and (if applicable prior to July 1, 1986) return on equity based on cost of ownership as determined in accordance with A and B above.

VIII. Refund of overpayments.

A. 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 review, 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's determination of the overpayment.

B. 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 also be used to reduce the remaining amount of the overpayment.

C. Payment schedule.

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 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 an extended repayment schedule.

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 the Department of Medical Assistance Services ("the director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an 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 amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

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

D. Extension request documentation.

In the 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.

E. Interest charge on extended repayment.

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.

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.

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 factfinding 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.

IX. Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals, which are exempted from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding sections I, II, III, IV, V, VI, VII, VIII and excluding V(6). Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are exempt from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports annually utilizing the applicable Medicare cost reporting forms (HCFA 2552 series) and the Medicaid forms (MAP-783 series).

A new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by the DMAS, which

represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating cost or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of IX.

X. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

XI. Pursuant to Item 389 E4 of the 1988 Appropriation Act (as amended), effective July 1, 1988, a separate group ceiling for allowable operating costs shall be established for state-owned university teaching hospitals.

XII. Nonenrolled providers.

A. Hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the DMAS average reimbursable inpatient cost-to-charge ratio, updated annually, for enrolled hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Hospitals that are not enrolled shall submit claims using the required DMAS invoice formats. Such claims must be submitted within 12 months from date of services. A hospital is determined to regularly treat Virginia Medicaid recipients and shall be required by DMAS to enroll if it provides more than 500 days of care to Virginia Medicaid recipients during the hospitals' financial fiscal year. A hospital which is required by DMAS to enroll shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding Sections I, II, III, IV, V, VI, VII, VIII, IX, and X. The hospital shall be placed in one of the DMAS peer groupings which most nearly reflects its licensed bed size and location (Section V.(1) above). These hospitals shall be required to maintain separate cost accounting records, and to file separate cost reports annually, utilizing the applicable Medicare cost reporting forms, (HCFA 2552 Series) and the Medicaid forms (MAP-783 Series).

B. A newly enrolled facility shall have an interim rate determined using the provider's most recent filed Medicare cost report or a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider shall be limited to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates shall be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of XII.A.

C. Once a hospital has obtained the enrolled status, 500 days of care, the hospital must agree to become enrolled as required by DMAS to receive reimbursement. This status shall continue during the entire term of the provider's current Medicare certification and subsequent recertification or until mutually terminated with 30 days written notice by either party. The provider must maintain this enrolled status to receive reimbursement. If an enrolled provider elects to terminate the enrolled agreement, the nonenrolled reimbursement status will not be available to the hospital for future reimbursement, except for emergency care.

D. Prior approval must be received from the DMAS Health Services Review Division when a referral has been made for treatment to be received from a nonenrolled acute care facility (in-state or out-of-state), except in the case of an emergency or because medical resources or supplementary resources are more readily available in another state.

E. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

XIII. Payment Adjustment Fund.

A. A Payment Adjustment Fund shall be created in each of the Commonwealth's fiscal years during the period July 1, 1992, to June 30, 1996. The Payment Adjustment Fund shall consist of the Commonwealth's cumulative addition of $5 million in general funds and its corresponding federal financial participation for reimbursement to nonstate-owned hospitals in each of the Commonwealth's fiscal years during this period. Each July 1, or as soon thereafter as is reasonably possible, the Commonwealth shall, through a single payment to each nonstate-owned hospital, equitably and fully disburse the Payment Adjustment Fund for that year.

B. In the absence of any amendment to the State Plan, Attachment 4.19A, for the Commonwealth's fiscal year after 1996, the Payment Adjustment Fund shall be continued at the level established in 1996 and shall be disbursed in accordance with the methodology described below.

C. The Payment Adjustment Funds shall be disbursed in accordance with the following methodology:

1. Identify each nonstate-owned hospital provider (acute, neonatal and rehabilitation) receiving payment based upon its peer group operating ceiling in May of each year.

2. For each such hospital identified in subdivision 1, identify its Medicaid paid days for the 12 months ending each May 31.

3. Multiply each such hospital's days under subdivision 2 by such hospital's May individual peer

group ceiling (i.e, disregarding such hospital's actual fiscal year end ceiling) as adjusted by its then current disproportionate share factor.

4. Sum all hospital amounts determined in subdivision 3.

5. For each such hospital, divide its amount determined in subdivision 3 by the total of such amounts determined in subdivision 4. This then becomes the hospital adjustment factor ("HAF") for each such hospital.

6. Multiply each such hospital's HAF times the amount of the Payment Adjustment Fund ("PAF") to determine its potential PAF share.

7. Determine the unreimbursed Medicaid allowable operating cost per day for each such hospital in subdivision 1 for the most recent fiscal year on file at DMAS as of May 31, inflate such costs by DRI-V+2 from the midpoint of such cost report to May 31 and multiply such inflated costs per day by the days identified for that hospital in subdivision 2, creating the "unreimbursed amount."

8. Compare each such hospital's potential PAF share to its unreimbursed amount.

9. Allocate to all hospitals, where the potential PAF share exceeds the unreimbursed amount, such hospital's unreimbursed amount as its actual PAF share.

10. If the PAF is not exhausted, for those hospitals with an unreimbursed amount balance, recalculate a new HAF for each such hospital by dividing the hospital's HAF by the total of the HAFs for all hospitals with an unreimbursed amount balance.

11. Recompute each hospital's new potential share of the undisbursed PAF by multiplying such funds by each hospital's new HAF.

12. Compare each hospital's new potential PAF share to its unreimbursed amount. If the unreimbursed amounts exceed the PAF shares at all hospitals, each hospital's new PAF share becomes its actual PAF share. If some hospitals' unreimbursed amounts are less than the new potential PAF shares, allocate to such hospitals their unreimbursed amount as their actual PAF share. Then, for those hospitals with an unreimbursed amount balance, repeat steps 10, 11 and 12 until each hospital's actual PAF share is determined and the PAF is exhausted.

13. The annual payment to be made to each nonstate-owned hospital from the PAF shall be equal to their actual PAF share as determined and allocated above. Each hospital's actual PAF share payment shall be made on July 1, or as soon thereafter as is reasonably feasible.

Footnotes:

[1] This effective date tracks an emergency regulation adopted September 29, 1988, by the Director of the Department of Medical Assistance Services, pursuant to the Code of Virginia § 9-6.14:9, and filed with the Registrar of Regulations. HCFA has not approved the inclusion of this disproportionate share adjustment policy's effective date in the State Plan for Medical Assistance.

[2] Refer to explanation at first footnote.

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Title of Regulation: **State Plan for Medical Assistance Relating to Provider Disputes and Date of Acquisition.**
VR 460-03-4.1912. Dispute Resolution for State-Operated Providers.
VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates--Other Types of Care.
VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).

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

Public Hearing Date: N/A – Written comments may be submitted until April 10, 1992.
(See Calendar of Events section for additional information)

Summary:

The purpose of this proposal is to (i) adopt a separate procedure for a state-operated provider to contest action taken by DMAS, and (ii) define the "date of acquisition" for revaluation of assets after a change of ownership of a nursing facility.

The sections of the State Plan for Medical Assistance affected by this proposed regulatory action are: Attachment 4.19 A (new Supplement 2 is being added), Attachment 4.19 B, and Attachment 4.19 D, the Supplement (containing the PIRS nursing home payment methodology).

Dispute Resolution for State-Operated Providers: A few state-operated facilities participate in the Medicaid program as contract providers. (Examples include hospitals, home health care agencies, hospital-based nursing facilities, institutions run by the Department of Mental Health, Mental Retardation and Substance Abuse Services, local health department clinics, pharmacies and outpatient dental laboratories, as well as other providers from time to time.) Because a state-operated facility or institution cannot sue or litigate against another agency or arm of the Commonwealth, existing appeal procedures under the Administrative Process Act (which contemplate court

review of an agency action) are not appropriate. Therefore, a separate procedure is being established to permit state-operated providers to resolve disagreements.

Date of Acquisition for Nursing Facilities: Federal law provides that, for reimbursement purposes, valuation of capital assets upon a change of ownership of a nursing facility cannot be increased by more than the lesser of two prescribed inflation indices as measured from the "date of acquisition by the seller" to the date of the change of ownership. The Patient Intensity Rating System nursing home payment system (PIRS) has never defined "date of acquisition." Representatives of the Health Care Financing Administration have defined "the date of acquisition" as the date when legal title passes. As a result of previous discussions between DMAS and providers, DMAS concludes that this term should be defined in PIRS and should also address situations where a nursing facility is constructed by an organization related to the provider (with no formal closing process and no date certain regarding legal title to the physical plant).

VR 460-03-4.1912. Dispute Resolution for State-Operated Providers.

§ 1. Definitions.

"DMAS" means the Department of Medical Assistance Services.

"Division director" means the director of a division of DMAS.

"State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

§ 2. Right to request reconsideration.

A. A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

B. The appropriate DMAS division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

§ 3. Informal review.

The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought, and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

§ 4. Division director action.

The division director shall consider any recommendation of his designee and shall render a decision.

§ 5. DMAS director review.

A state-operated provider may, within 30 days after receiving the informal review decision of the division director, request that the DMAS director or his designee review the decision of the division director. The DMAS director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

§ 6. Secretarial review.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates—Other Types of Care.

The policy and the method to be used in establishing payment rates for each type of care or service (other than inpatient hospitalization, skilled nursing and intermediate care facilities) listed in § 1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs:

a. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the Plan at least to the extent these are available to the general population.

b. Participation in the program will be limited to providers of services who accept, as payment in full, the state's payment plus any copayment required under the State Plan.

c. Payment for care or service will not exceed the amounts indicated to be reimbursed in accord with the policy and methods described in this Plan and payments will not be made in excess of the upper limits described

in 42 CFR 447.304(a). The state agency has continuing access to data identifying the maximum charges allowed: such data will be made available to the Secretary, HHS, upon request.

d. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The 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, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has 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 changes in financial position;

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.

Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

The services that are cost reimbursed are:

(1) Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals

(2) Home health care services

(3) Outpatient hospital services excluding laboratory

(4) Rural health clinic services provided by rural health clinics or other federally qualified health centers defined as eligible to receive grants under the Public Health Services Act §§ 329, 330, and 340.

(5) Rehabilitation agencies

(6) Comprehensive outpatient rehabilitation facilities

(7) Rehabilitation hospital outpatient services.

e. Fee-for-service providers. (1) Payment for the following services shall be the lowest of: State agency fee schedule, actual charge (charge to the general public), or Medicare (Title XVIII) allowances:

(a) Physicians' services (Supplement 1 has obstetric/pediatric fees.)

(b) Dentists' services

(c) Mental health services including:

Community mental health services

Services of a licensed clinical psychologist

Mental health services provided by a physician

(d) Podiatry

(e) Nurse-midwife services

(f) Durable medical equipment

(g) Local health services

(h) Laboratory services (Other than inpatient hospital)

(i) Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling)

(j) X-Ray services

(k) Optometry services

(l) Medical supplies and equipment.

(2) Hospice services payments must be no lower than the amounts using the same methodology used under part A of Title XVIII, and adjusted to disregard offsets attributable to Medicare coinsurance amounts.

f. Payment for pharmacy services shall be the lowest of items (1) through (5) (except that items (1) and (2) will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.331 (c) if the

brand cost is greater than the HCFA upper limit of VMAC cost) subject to the conditions, where applicable, set forth in items (6) and (7) below:

(1) The upper limit established by the Health Care Financing Administration (HCFA) for multiple source drugs pursuant to 42 CFR §§ 447.331 and 447.332, as determined by the HCFA Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

(2) The Virginia Maximum Allowable Cost (VMAC) established by the agency plus a dispensing fee, if a legend drug, for multiple source drugs listed on the VVF.

(3) The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percent discount established by the methodology set out in (a) through (c) below. (Pursuant to OBRA 90 § 4401, from January 1, 1991, through December 31, 1994, no changes in reimbursement limits or dispensing fees shall be made which reduce such limits or fees for covered outpatient drugs).

(a) Percent discount shall be determined by a statewide survey of providers' acquisition cost.

(b) The survey shall reflect statistical analysis of actual provider purchase invoices.

(c) The agency will conduct surveys at intervals deemed necessary by DMAS, but no less frequently than triennially.

(4) A mark-up allowance (150%) of the Estimated Acquisition Cost (EAC) for covered nonlegend drugs and oral contraceptives.

(5) The provider's usual and customary charge to the public, as identified by the claim charge.

(6) Payment for pharmacy services will be as described above; however, payments for legend drugs (except oral contraceptives) will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Payments will be reduced by the amount of the established copayment per prescription by noninstitutionalized clients with exceptions as provided in federal law and regulation.

(7) The Program recognizes the unit dose delivery system of dispensing drugs only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose add on fee and an allowance for the cost of unit dose packaging established by the state agency. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC based on the 60th percentile cost level identified by the state agency or HCFA's upper limits. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency.

(8) Historical determination of EAC. Determination of EAC was the result of an analysis of FY'89 paid claims data of ingredient cost used to develop a matrix of cost using 0 to 10% reductions from AWP as well as discussions with pharmacy providers. As a result of this analysis, AWP minus 9.0% was determined to represent prices currently paid by providers effective October 1, 1990.

The same methodology used to determine AWP minus 9.0% was utilized to determine a dispensing fee of $4.40 per prescription as of October 1, 1990. A periodic review of dispensing fee using Employment Cost Index - wages and salaries, professional and technical workers will be done with changes made in dispensing fee when appropriate. As of October 1, 1990, the Estimated Acquisition Cost will be AWP minus 9.0% and dispensing fee will be $4.40.

g. All reasonable measures will be taken to ascertain the legal liability of third parties to pay for authorized care and services provided to eligible recipients including those measures specified under 42 USC 1396(a)(25).

h. The single state agency will take whatever measures are necessary to assure appropriate audit of records whenever reimbursement is based on costs of providing care and services, or on a fee-for-service plus cost of materials.

i. Payment for transportation services shall be according to the following table:

TYPE OF SERVICE	PAYMENT METHODOLOGY
Taxi services	Rate set by the single state agency
Wheelchair van	Rate set by the single state agency
Nonemergency ambulance	Rate set by the single state agency
Emergency ambulance	Rate set by the single state agency
Volunteer drivers	Rate set by the single state agency
Air ambulance	Rate set by the single state agency
Mass transit	Rate charged to the public
Transportation	Rate set by the single

agreements	state agency
Special Emergency transportation	Rate set by the single state agency

j. Payments for Medicare coinsurance and deductibles for noninstitutional services shall not exceed the allowed charges determined by Medicare in accordance with 42 CFR 447.304(b) less the portion paid by Medicare, other third party payors, and recipient copayment requirements of this Plan. See Supplement 2 for this methodology.

k. Payment for eyeglasses shall be the actual cost of the frames and lenses not to exceed limits set by the single state agency, plus a dispensing fee not to exceed limits set by the single state agency.

l. Expanded prenatal care services to include patient education, homemaker, and nutritional services shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

m. Targeted case management for high-risk pregnant women and infants up to age 1 shall be reimbursed at the lowest of: state agency fee schedule, actual charge, or Medicare (Title XVIII) allowances.

n. Reimbursement for all other nonenrolled institutional and noninstitutional providers.

(1) All other nonenrolled providers shall be reimbursed the lesser of the charges submitted, the DMAS cost to charge ratio, or the Medicare limits for the services provided.

(2) Outpatient hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid based on the DMAS average reimbursable outpatient cost-to-charge ratio, updated annually, for enrolled outpatient hospitals less five percent. The five percent is for the cost of the additional manual processing of the claims. Outpatient hospitals that are nonenrolled shall submit claims on DMAS invoices.

(3) Nonenrolled providers of noninstitutional services shall be paid on the same basis as enrolled in-state providers of noninstitutional services. Nonenrolled providers of physician, dental, podiatry, optometry, and clinical psychology services, etc., shall be reimbursed the lesser of the charges submitted, or the DMAS rates for the services.

(4) All nonenrolled noninstitutional providers shall be reviewed every two years for the number of Medicaid recipients they have served. Those providers who have had no claims submitted in the past twelve months shall be declared inactive.

(5) Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

o. Refund of overpayments.

(1) Providers reimbursed on the basis of a fee plus cost of materials.

(a) When DMAS determines an overpayment has been made to a provider, 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's determination of the overpayment.

(b) If the provider cannot refund the total amount of the overpayment within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

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 the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an 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 amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program, the outstanding balance shall become immediately due and payable.

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

(c) In the 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.

(d) Once an initial determination of overpayment

has been made, DMAS shall undertake full recovery of such overpayment whether 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.

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.

The director's determination shall be deemed to be final on (i) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (ii) the issue date factfinding conference, if the provider does not file an appeal, or (iii) 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.

(2) Providers reimbursed on the basis of reasonable costs.

(a) 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 review, 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's determination of the overpayment.

(b) 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 also be used to reduce the remaining amount of the overpayment.

(c) 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 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 an extended repayment schedule.

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 the Department of Medical Assistance Services (the "director") may approve a repayment schedule of up to 36 months.

A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an 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 amount.

If, during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

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

(d) In the 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.

(e) 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.

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.

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 factfinding 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.

p. Dispute resolution for state-operated providers

(1) Definitions.

(a) "DMAS" means the Department of Medical Assistance Services.

(b) "Division director" means the director of a division of DMAS.

(c) "State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

(2) Right to request reconsideration.

(a) A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

(b) The appropriate DMAS division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

(3) Informal review. The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought, and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

(4) Division director action. The division director shall consider any recommendation of his designee and shall render a decision.

(5) DMAS director review. A state-operated provider may, within 30 days after receiving the informal review decision of the division director, request that the DMAS director or his designee review the decision of the division director. The DMAS director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

(6) Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after the receipt of the decision of the DMAS director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

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. 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.

§ 3.6. Dispute resolution for state-operated NFs.

A. Definitions.

1. "DMAS" means the Department of Medical Assistance Services.

2. "Division director" means the director of a division of DMAS.

3. "State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

B. Right to request reconsideration.

1. A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a nonstate operated provider. This shall be the sole procedure available to state-operated providers.

2. The appropriate DMAS division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

C. Informal review.

The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought, and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

D. Division director action.

The division director shall consider any recommendation of his designee and shall render a decision.

E. DMAS director review.

A state-operated provider may, within 30 days after receiving the informal review decision of the division director, request that the DMAS director or his designee review the decision of the division director. The DMAS director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

F. Secretarial review.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.

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.

E. Date of acquisition is deemed to have occurred on the date legal title passed to the seller. If a legal titling date is not determinable, date of acquisition shall be considered to be the date a certificate of occupancy was issued by the appropriate licensing or building inspection agency of the locality where the nursing facility is located.

BOARD OF MEDICINE

Title of Regulation: **VR 465-05-01. Regulations Governing the Practice of Physicians' Assistants.**

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until April 13, 1992.
(See Calendar of Events section for additional information)

Summary:

The proposed amendments to the current regulations (i) establish the procedures for maintaining records of approved invasive procedures performed by the physician's assistant; (ii) provide reports to the board, upon request, of the number of procedures performed and complications of such procedures; (iii) establish unprofessional conduct for failure to maintain records of all invasive procedures performed by the physician's assistant; establish scope of practice by specialty of the supervising physician; and establish any acute or significant finding or changes of a patient's clinical status by a physician's assistant must be reported within one hour to the supervising physician.

VR 465-05-01. Regulations Governing the Practice of Physician's Assistants.

PART I.
GENERAL PROVISIONS.

§ 1.1. Definitions.

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

"Assistant to a Doctor of Medicine, Osteopathy, or Podiatry," or *"Physician's Assistant,"* means an individual who is qualified as an auxiliary paramedical person by academic and clinical training and is functioning in a dependent-employee relationship with a doctor of medicine, osteopathy, or podiatry licensed by the board.

"Board" means the Virginia Board of Medicine.

"Committee" means the Advisory Committee on Physician's Assistants appointed by the president of the board to advise the board on matters relating to physician's assistants. The committee is composed of four members of the board, one supervising physician, and two

physician's assistants.

"Group practice" means the practice of a group of two or more doctors of medicine, osteopathy, or podiatry licensed by the board who practice as a partnership or professional corporation.

"Institution" means a hospital, nursing home or other health care facility, community health center, public health center, industrial medicine or corporation clinic, a medical service facility, student health center, or other setting approved by the board.

"NCCPA" means the National Commission on Certification of Physician Assistants.

"Protocol" means a set of directions developed by the supervising physician that defines the supervisory relationship between the physician assistant and the physician and the circumstances under which the physician will see and evaluate the patient.

"Supervision means":

1. *"Alternate supervising physician"* means a member of the same group or professional corporation or partnership of any licensee, any hospital or any commercial enterprise with the supervising physician. Such alternating supervising physician shall be a physician licensed in the Commonwealth of Virginia who has registered with the board and who has accepted responsibility for the supervision of the service that a physician's assistant renders.

2. *"Direct supervision"* means the physician is in the room in which a procedure is being performed.

3. *"General supervision"* means the supervising physician is easily available and can be physically present within one hour.

4. *"Personal supervision"* means the supervising physician is within the facility in which the physician's assistant is functioning.

5. *"Supervising physician"* means the supervising physician who makes application to the board for licensure of the assistant.

6. *"Substitute supervising physician"* means a doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth of Virginia who has accepted responsibility for the supervision of the service that a physician's assistant renders in the absence of such assistant's supervising physician.

§ 1.2. Applicability.

These regulations apply to physician's assistants only, as defined in § 1.1.

§ 1.3. A separate board regulation, VR 465-01-01, entitled Public Participation Guidelines, which provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine, is incorporated by reference in these regulations.

PART II.
REQUIREMENTS FOR PRACTICE AS A PHYSICIAN'S ASSISTANT.

§ 2.1. Requirements, general.

A. No person shall practice as a physician's assistant in the Commonwealth of Virginia except as provided in these regulations.

B. All services rendered by a physician's assistant shall be performed only under the supervision of a doctor of medicine, osteopathy, or podiatry licensed by this board to practice in the Commonwealth of Virginia.

§ 2.2. Certification, entry requirements and application.

A. A certificate to practice as a physician's assistant shall be obtained from the board before such assistant begins to practice with a supervising doctor of medicine, osteopathy, or podiatry.

B. Entry requirements.

An applicant for certification shall:

1. Possess the educational qualifications prescribed in § 2.3 of these regulations; and

2. Meet the requirements for examination prescribed in §§ 3.1 through 3.3 of these regulations.

C. Application for board approval of a physician's assistant shall be submitted to the board by the supervising physician under whom the assistant will work, and who will assume the responsibility for the assistant's performance. By submitting the application, the supervising physician attests to the general competence of the assistant. In a group or institutional practice setting, the supervising physician shall be the contact for the board regardless of whether the supervision has been delegated to an alternate or substitute supervising physician.

D. The application shall:

1. Be made on forms supplied by the board and completed in every detail ;.

2. Spell out the roles and functions of the assistant with a protocol acceptable to the board and any such protocols shall take into account such factors as the number of patients, the types of illness treated by the physician, the nature of the treatment, special procedures, and the nature of the physician's availability in ensuring direct physician involvement at

an early stage and regularly thereafter ; .

a. The board may require, at its discretion, in a supplement to the application, information regarding the level of supervision, "direct," "personal" or "general," with which the supervising physician plans to supervise the physician's assistant for selected tasks. The board may also require the supervising physician to document the assistant's competence in performing such tasks.

b. The supervising physician shall maintain records of all approved invasive procedures performed by the physician's assistant.

c. The supervising physician shall report to the board the number of invasive procedures performed by the physician's assistant and complications resulting from the procedures, on forms provided by the board.

d. Failure to maintain records of invasive procedures performed by the physician's assistant, or provide a report to the board, shall be considered unprofessional conduct.

3. Provide that, if for any reason the assistant discontinues working in the employment and under the supervision of the licensed practitioner who submitted the application:

a. Such assistant and the employing practitioner shall so inform the board and the assistant's approval shall terminate.

b. A new application shall be submitted to the board and approved by the board in order for the assistant either to be reemployed by the same practitioner or to accept new employment with another supervising physician.

E. The application fee prescribed in § 5.1 of these regulations shall be paid at the time the application is filed.

§ 2.3. Educational requirements.

An applicant for certification shall:

1. Have successfully completed a prescribed curriculum of academic study in a school or institution accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association and accredited by the American Academy of Physician Assistants; and

2. Present documented evidence of eligibility for the NCCPA examination or completed certification requirements.

PART III.

EXAMINATION.

§ 3.1. The proficiency examination of the NCCPA constitutes the board examination required of all applicants for certification.

§ 3.2. Provisional registration.

An applicant who has met the requirements of the board at the time his initial application is submitted may be granted provisional registration by the board if he meets the provisions of § 54.1-2950 of the Code of Virginia and § 2.3 of these regulations. Such provisional registration shall be subject to the following conditions:

~~A.~~ *1.* The provisional registration shall be valid until the applicant takes the next subsequent NCCPA examination and its results are reported, but this period of validity shall not exceed 30 days following the reporting of the examination scores.

~~B.~~ *2.* An applicant who fails the examination may be granted individual consideration by the board and granted an extension of the provisional registration upon evidence that he is eligible for admission to the next scheduled board examination.

§ 3.3. Examination.

A. Every applicant shall take the NCCPA examination at the time scheduled by the NCCPA.

B. An applicant who fails the examination three consecutive times shall surrender his certificate to practice until proof has been provided to the board that the standards of NCCPA have been met.

§ 3.4. Renewal of certificate.

A. Every certified physician's assistant intending to continue his practice shall annually on or before July 1:

1. Register with the board for renewal of his certificate;

2. Present documented evidence of compliance with continuing medical education standards established by the NCCPA; and

3. Pay the prescribed renewal fee at the time he files for renewal.

B. Any physician's assistant who allows his NCCPA certification to lapse shall be considered not certified by the board. Any such assistant who proposes to resume his practice shall make a new application for certification.

PART IV.
INDIVIDUAL RESPONSIBILITIES.

§ 4.1. Individual responsibilities.

A supervising physician and the physician's assistant working with him shall observe the following division of responsibilities in the care of patients:

A. The supervising physician shall:

1. See and evaluate any patient who presents with the same complaint twice in a single episode of care and has failed to improve significantly. Such physician involvement shall occur not less frequently than every fourth visit for a continuing illness.

2. Review the record of services rendered the patient by the physician's assistant and sign such records within 24 hours after any such care was rendered by the assistant.

3. Be responsible for all invasive procedures. Under general supervision, a physician's assistant may insert a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow-directed catheter, and may perform minor suturing, venipuncture, and subcutaneous intramuscular or intravenous injection.

All other invasive procedures not listed above must be performed under direct supervision unless, after directly supervising the performance of a specific invasive procedure three times or more, the supervising physician attests to the competence of the physician's assistant to perform the specific procedure without direct supervision by certifying to the board in writing the number of times the specific procedure has been performed and that the physician's assistant is competent to perform the specific procedure. After such certification has been accepted and approved by the board, the physician's assistant may perform the procedure under general supervision.

B. The physician's assistant shall not render independent health care. Such assistant:

1. Shall perform only those medical care services that are within the scope of the practice and proficiency of the supervising physician as prescribed in the physician's assistants protocol. *When a physician's assistant is to be supervised by an alternate supervising physician, outside the scope of specialty of the supervising physician, then the physician's assistant's functions shall be limited to those areas not requiring specialized clinical judgment, unless a separate protocol for that alternate supervising physician is approved and on file with the board.*

2. Shall not sign prescriptions.

3. Shall, during the course of performing his duties, wear identification showing clearly that he is a physician's assistant.

C. If the assistant is to perform duties away from the supervising physician, such supervising physician shall obtain board approval in advance for any such arrangement and shall establish written policies to protect the patient.

D. If, due to illness, vacation, or unexpected absence, the supervising physician is unable to supervise personally the activities of his assistant, such supervising physician may temporarily delegate the responsibility to another doctor of medicine, osteopathy, or podiatry. The employing supervising physician so delegating his responsibility shall report such arrangement for coverage, with the reason therefor, to the board office in writing, subject to the following provisions:

1. For planned absence, such notification shall be received at the board office at least one month prior to the supervising physician's absence.

2. For sudden illness or other unexpected absence, the board office shall be notified as promptly as possible, but in no event later than one week.

3. Temporary coverage may not exceed four weeks unless special permission is granted by the board.

E. With respect to assistants employed by institutions, the following additional regulations shall apply:

1. No assistant may render care to a patient unless the physician responsible for that patient has signed an application to act as supervising physician for that assistant. The board shall make available appropriate forms for physicians to join the application for an assistant employed by an institution.

2. Any such application as described in subdivision 1 above shall delineate the duties which said physician authorizes the assistant to perform.

3. The assistant shall as soon as circumstances may dictate but, within an hour, *with an acute or significant finding or change in clinical status,* report to the supervising physician concerning the examination of the patient. The assistant shall also record his findings in appropriate institutional records.

4. No physician assistant shall perform the initial evaluation, or institute treatment of a patient who presents to the emergency room or is admitted to the hospital for a life threatening illness or injury. In noncritical care areas, the physician assistant may perform the initial evaluation in an inpatient setting provided the supervising physician evaluates the patient within eight hours of the physician assistant's initial evaluation.

PART V.
FEES.

§ 5.1. The following fees are required:

A. The application fee, payable at the time application is filed, shall be $100.

B. The annual fee for renewal of registration, payable on or before July 1, shall be $40.

C. An additional fee to cover administrative costs for processing a late application may be imposed by the board. The additional fee for late renewal of licensure shall be $10 for each renewal cycle.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (BOARD OF)

Title of Regulation: **VR 470-05-01. Regulation for Certification of Case Management.**

Statutory Authority: §§ 37.1-10 and 37.1-179 et seq. of the Code of Virginia and § I-92 Item 466.F.5 of the 1990-92 Appropriations Act.

Public Hearing Date: N/A–Written comments may be submitted until April 10, 1992.
(See Calendar of Events section for additional information)

Summary:

The proposed regulations establish requirements which facilities must meet in order to receive reimbursement from Medicaid for Case Management Services. The regulations require that case managers meet knowledge, skills and abilities set forth in the regulations and that facilities meet the standards established by the regulations.

VR 470-05-01. Regulation for Certification of Case Management.

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.

"Case management services" means assisting individual children, adults, and their families in accessing needed medical, psychiatric, social, educational, vocational and other supports essential to meeting basic needs.

"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.

"Facility" means any facility not operated by an agency of the federal government by whatever name or designation which provides case management services to mentally ill or mentally retarded persons. Such institution or facility shall include a hospital as defined in § 32.1-123 of the Code of Virginia, outpatient clinic, special school, halfway house, home and any other similar or related facility.

"Mentally ill" means any person afflicted with mental disease to such an extent that for his own welfare or the welfare of others, he requires care and treatment.

"Mental retardation" means substantial subaverage general intellectual functioning which originates during the development period and is associated with impairment in adaptive behavior.

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 case management 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 Case Management Certification

§ 1.4. A facility desiring to be certified or recertified for case management services shall submit to the Commissioner a letter stating that all individuals providing case management services for which reimbursement from the Department of Medical Assistance Services will be sought possess a combination of applicable mental health or mental retardation work experience or related education which indicates that the

individual possesses the knowledge, skills and abilities (KSAs) as established by the department and attached hereto which are necessary to perform case management services. This letter shall constitute the application for certification. This letter shall clearly identify the entity that is seeking certification and is responsible for ensuring compliance with all certification requirements.

§ 1.5. Every facility shall be designated by a permanent and distinctive name and physical location which shall appear in the application for certification or certification renewal and which shall not be changed without first securing approval of the department.

§ 1.6. The terms of any certification issued shall include: (i) the operating name of the facility; (ii) the name of the entity to whom the certification is issued; (iii) the physical location of the facility; (iv) the effective dates of the certification; and (v) other specifications prescribed within the context of the regulations.

Article 5.
The Certification.

§ 1.7. The commissioner may certify a facility for the provision of case management services for which reimbursement is sought from the Department of Medical Assistance Services only after he is satisfied that all individuals providing services for which Medicaid reimbursement will be sought meet applicable KSAs. In addition, the commissioner must be satisfied that the facility can:

1. Guarantee that clients have access to emergency services on a 24-hour basis;

2. Demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

3. Meet the administrative and financial management requirements of state and federal regulations;

4. Document and maintain individual case records in accordance with state and federal requirements;

5. Ensure that services are in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services;

6. Provide comprehensive mental health services if the facility provides mental health case management; and

7. Provide comprehensive mental retardation services if the facility provides mental retardation case management.

§ 1.8. The commissioner may issue a certification to a facility that has fulfilled the conditions listed in § 1.7 for any period not to exceed two years from its date of issuance, unless it is revoked or surrendered earlier.

§ 1.9. 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 in a facility or institution certified under these regulations.

2. Conduct or practices detrimental to the welfare of any client of a facility or institution certified under these regulations.

3. Failure to employ individuals who meet the standards set forth under these regulations.

§ 1.10. 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.

§ 1.11. 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.

§ 1.12. 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 appear to so require and the interests of the public will not be jeopardized.

Article 6.
Inspection.

§ 1.13. Each applicant or certified facility agrees as a condition of application or certification to permit properly designated representatives of the department to examine records including employee personnel records to verify information contained in the application.

PART II.
REQUIREMENTS.

Article 1.
Staff Qualifications.

§ 2.1. For services reimbursable by the Department of Medical Assistance Services, the facility shall employ only individuals who possess a combination of applicable mental health work experience or related education which indicates that the individual possesses the knowledge, skills and abilities as established by the department which are necessary to perform case management services for the mentally ill.

§ 2.2. For services reimbursable by the Department of Medical Assistance Services, the facility shall employ only

individuals who possess a combination of applicable mental retardation work experience or related education which indicates that the individual possesses the knowledge, skills and abilities as established by the department which are necessary to perform case management services for persons with mental retardation.

Article 2.
Facility Requirements.

§ 2.3. The facility shall:

1. Guarantee that clients have access to emergency services on a 24-hour basis;

2. Demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

3. Have the administrative and financial management capacity to meet state and federal requirements;

4. Have the ability to document and maintain individual case records in accordance with state and federal requirements;

5. Ensure that services are in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services;

6. Provide comprehensive mental health services if the facility provides mental health case management; and

7. Provide comprehensive mental retardation services if the facility provides mental retardation case management.

* * *

SAMPLE POSITION SPECIFICATION

POSITION TITLE: Medicaid Mental Health Case Manager

GENERAL STATEMENT OF DUTIES:

This position is responsible for providing case management services to clients who are eligible for or enrolled in the Medical Assistance Program (Medicaid). The case manager's activities may include preadmission and predischarge planning, services coordination and delivery, assistance in accessing needed medical, psychiatric, social, educational, vocational and other supports, as required, and casework documentation.

In carrying out the responsibilities of this position, the case manager reports to and receives general supervision from a designated supervisor for case management services or other appropriate clinical supervisor. The incumbent is expected to exercise sound judgment, demonstrate initiative and maintain confidentiality in accordance with established policies and procedures which comply with legal and administrative mandates.

EXAMPLES OF MAJOR DUTIES:

1. Assessing needs and planning services, evaluating individual strengths and needs, evaluating the appropriateness of and need for various community mental health services, developing individual service plans, and monitoring and evaluating client status.

2. Linking the individual directly to services and supports specified in the individual service plan.

3. Assisting the individual directly for the purpose of locating, obtaining and effectively using community resources, including educating and monitoring information and support to family members, and providing or arranging for transportation for individuals or their family members to access services.

4. Coordinating services with other agencies and providers involved with the individual (e.g., Department of Social Services, Department of Rehabilitative Services, Health Department, school division, Area Agency on Aging, Social Security Administration); this also includes assisting clients or their family members to apply for benefits which they are eligible to receive.

5. Enhancing community adjustment and integration by developing services or supports which increase opportunities for community access and involvement, including developing community living skills and vocational, civic and recreational services.

6. Making collateral contacts with the individual's significant others (e.g., parents, friends and siblings) to promote implementation of the service plan and optimal community adjustment.

7. Monitoring service delivery with the client to assure the adequacy and implementation of the individual service plan and to assess the individual's receipt of and participation in appropriate types and levels of services, goal attainment, need for additional assistance and continued appropriateness of service settings.

8. Maintaining necessary casework records to document the provision of case management services for Medicaid reimbursement.

9. Attending in-service training and staff development programs to enhance the case management services.

10. Performing other duties as assigned related to program requirements and the provision of case management services.

POSITION QUALIFICATIONS:

The incumbent must have at entry level the following knowledge, skills and abilities. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

KNOWLEDGE OF:

- the nature of serious mental illness in adults and serious emotional disturbance in children and adolescents
- treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination
- different types of assessments, including functional assessment, and their uses in service planning
- consumers' rights
- local community resources and service delivery systems, including support services (e.g., housing, financial, social welfare, dental, educational, transportation, communications, recreation, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g., churches, clubs, self-help groups)
- types of mental health programs and services
- effective oral, written and interpersonal communication principles and techniques
- general principles of record documentation
- the service planning process and major components of a service plan

SKILLS IN:

- interviewing
- observing, recording and reporting on an individual's functioning
- identifying and documenting a consumer's need for resources, services and other supports
- using information from assessments, evaluations, observation and interviews to develop service plans
- identifying services within the community and established service system to meet the individual's needs
- formulating, writing and implementing individualized service plans to promote goal attainment for seriously mentally ill and emotionally disturbed persons
- negotiating with consumers and service providers
- coordinating the provision of services by diverse public and private providers
- identifying community resources and organizations and coordinating resources and activities
- using assessment tools (e.g., level of function scale, life profile scale)

ABILITIES TO:

- demonstrate a positive regard for consumers and their families (e.g., treating consumers as individuals, allowing risk taking, avoiding stereotypes of mentally-ill people, respecting consumers' and families' privacy, believing consumers are valuable members of society)
- be persistent and remain objective
- work as a team member, maintaining effective inter- and intra-agency working relationships
- work independently, performing position duties under general supervision
- communicate effectively, verbally and in writing

BUSINESS NECESSITY QUALIFICATIONS:

The incumbent must have a valid Virginia driver's license.

* * *

SAMPLE POSITION SPECIFICATION

POSITION TITLE: Medicaid Mental Retardation Case Manager

GENERAL STATEMENT OF RESPONSIBILITIES:

This position is responsible for providing case management services to clients who are eligible for or enrolled in targeted case management as reimbursed through the Medical Assistance Program (Medicaid). The case manager's activities may include linking and coordination of resources and monitoring of service provision.

In carrying out the responsibilities of this position, the case manager reports to and receives general supervision from the case management services supervisor or, in small programs, the MR Director. The incumbent is expected to exercise sound judgment, demonstrate initiative and maintain confidentiality in accordance with established policies and procedures which comply with legal and

administrative mandates.

EXAMPLES OF MAJOR DUTIES:

1. Assessing needs and planning services, determining the appropriateness of, and need for, mental retardation services, evaluating individual needs, reevaluating individual needs periodically, and developing consumer service plans.

2. Linking the individual to services and supports specified in the consumer service plan.

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources, including crisis services; this also includes providing or arranging for transportation for individuals or their family members to access services.

4. Coordinating services with other agencies and providers involved with the individual (e.g., Department of Social Services, Department of Rehabilitative Services, Health Department, school division, Area Agency on Aging, Social Security Administration); this also includes assisting clients or their family members to apply for benefits which they are eligible to receive.

5. Enhancing community integration by developing increased opportunities for community access and involvement, including community living skills and vocational, civic and recreational services.

6. Making collateral contacts with the individual's significant others (e.g., parents, guardians, friends, and siblings) to promote implementation of the services plan and community adjustment.

7. Monitoring service delivery to assure implementation of the consumer service plan and to assess the individual's receipt of and participation in appropriate types and levels of services.

8. Maintaining necessary casework records to document the provision of case management services for Medicaid reimbursement.

9. Attending in-service training and staff development programs to enhance the case management services.

10. Performing other duties as assigned related to program requirements and the provision of case management services.

POSITION QUALIFICATIONS:

The incumbent must have at entry level the following knowledge, skills and abilities. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

KNOWLEDGE OF:

- the definition, causes and program philosophy of mental retardation
- different types of assessments and their uses in program planning
- consumers' rights
- local service delivery systems, including support services
- types of mental retardation programs and services
- effective oral, written and interpersonal communication principles and techniques
- general principles of record documentation
- the service planning process and the major components of a service plan
- treatment modalities and intervention techniques, such as behavior management, independent living, skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination

SKILLS IN:

- negotiating with consumers and service providers
- observing, recording and reporting behaviors
- identifying and documenting a consumer's needs for resources, services and other assistance
- identifying services within the established service system to meet the consumer's needs
- coordinating the provision of services by diverse public and private providers
- analyzing and planning for the service needs of mentally retarded persons
- interviewing
- formulating, writing and implementing individualized service plans to promote goal attainment for persons with mental retardation
- using assessment tools

ABILITIES TO:

- demonstrate a positive regard for consumers and their families (e.g., treating consumers as individuals, allowing risk taking, avoiding stereotypes of mentally retarded people, respecting consumers' and families'

privacy, believing consumers can grow)

• be persistent and remain objective

• work as a team member, maintaining effective inter- and intra-agency working relationships

• work independently, performing position duties under general supervision

• communicate effectively, verbally and in writing

BUSINESS NECESSITY QUALIFICATIONS:

The incumbent must have a valid Virginia driver's license.

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

Title of Regulation: **VR 615-70-17. Child Support Enforcement Program.**

Statutory Authority: §§ 63.1-25, 63.1-249 and 63.1-274.10 of the Code of Virginia.

Public Hearing Date: N/A – Written comments may be submitted until April 10, 1992.

Summary:

The proposed revision to the child support regulation would allow the department to administratively deviate from Virginia's child support guideline by considering other child support obligations when calculating a new obligation. It would also allow the department to use data on the cost of raising a child in the urban south published by the United States Department of Agriculture to establish an obligation when the absent parent does not provide financial information. It revises the release of information requirements to allow the department to release financial information to each parent. It also clarifies terminology used in the regulation.

VR 615-70-17. Child Support Enforcement Program.

PART I.
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:

"Absent parent" means a responsible parent as defined in the Code of Virginia who is required under law to support a dependent child or the dependent child and the child's caretaker.

"ADC" means Aid to Dependent Children which is established under Title IV-A of the Social Security Act. This is a category of financial assistance paid on behalf of children who are deprived of one or both of their parents by reason of death, disability, or continued absence (including desertion) from the home. established under Title IV-E of the Social Security Act. This is a category of financial assistance paid on behalf of children who otherwise meet the eligibility criteria for ADC and who are in the custody of the local social service agencies.

"ADC/FC" means Aid to Dependent Children/Foster Care which is established under Title IV-E of the Social Security Act. This is a category of financial assistance paid on behalf of children who otherwise meet the eligibility criteria for ADC and who are in the custody of local social services agencies.

"Administrative" means noncourt ordered, legally enforceable actions the department may take to establish or enforce a child support obligation.

"Appeal" means a request for a review of an action taken by the division.

"Application" means a written document requesting child support enforcement services which the department provides to the individual or agency applying for services and which is signed by the custodial parent or agency representative.

"Arrears" means the total unpaid support obligation established by court order or administrative order which is owed by an absent parent to a custodial parent.

"Assignment" means any assignment of rights to support or any assignment of rights to medical support and to payments for medical care from any third party.

"Bad check" means a check not honored by the bank on which it is drawn.

"Custodial parent" means (i) the natural or adoptive parent with whom the child resides, (ii) a step-parent or other person who has ~~legal~~ *physical* custody of the child and with whom the child resides, or (iii) a social service agency which has legal custody of a child in foster care.

"Debt" means the ~~total unpaid support obligation established by court order, administrative order, or payment~~ *amount* of public assistance *payments* which ~~is~~ *are* owed by an absent ~~responsible~~ parent to ~~either the custodial parent or to~~ the Commonwealth.

"Default obligation" means an obligation based on factors other than the absent parent's ability to pay because of the absent parent's failure to provide financial information.

"Delinquent" means an unpaid child support obligation.

"Department" means the Virginia Department of Social Services.

"Disregard payment" means a payment made to an ADC recipient in an amount up to $50. The payment is made from the current child support collected on the individual's behalf.

"District office" means a local office of the Division of Child Support Enforcement responsible for the operation of the Child Support Enforcement Program.

"Division" means the Division of Child Support Enforcement of the Virginia Department of Social Services.

"Enforcement" means ensuring the payment of child support through the use of administrative or judicial means.

"Erroneous payment" means a payment sent to the custodial parent for which no funds were received by the department to be paid to that client.

"Financial statement" means ~~a sworn document~~ *financial information* from the custodial parent and absent ~~responsible~~ parent showing their financial situation.

"Foreclosure" means a judicial procedure to enforce debts involving forced judicial sale of the real property of a debtor.

"Health ~~care~~ insurance coverage" means any plan providing hospital, medical, or surgical care coverage for dependent children provided such coverage is available and can be obtained by an absent responsible parent at a reasonable cost.

"Hearings officer" means a disinterested person designated by the department to hold appeal hearings and render appeal decisions.

"IV-D agency" means a governmental entity administering the child support program under Title IV-D of the Social Security Act. In Virginia the IV-D agency is the Division of Child Support Enforcement.

"Judicial" means an action initiated through a court.

"Location only services" means that certain entities such as courts and other state child support enforcement agencies can receive only locate services from the department.

"Local social service agency" means one of Virginia's locally administered social service or welfare departments which operate the ADC and ADC/FC programs and other programs offered by the department.

"Location" means obtaining information which is sufficient and necessary to take action on a child support case including information concerning (i) the physical whereabouts of the absent parent or his employer, or (ii) other sources of income or assets, as appropriate.

"Medicaid only" means a category of public assistance whereby a family receives Medicaid but is not eligible for or receiving ADC.

"Medical support services" means the establishment of a medical support order and the enforcement of health insurance coverage or, if court ordered, medical expenses.

"Mistake of fact" means an error in the identity of the absent ~~responsible~~ parent or in the amount of child support owed.

"Obligation" means the amount and frequency of payments which the absent ~~responsible~~ parent is legally bound to pay.

"Pendency of an appeal" means the period of time after an administrative appeal has been made and before the final disposition.

"Public assistance" means payments for ADC, or ADC/FC, or Medicaid-only.

"Putative father" means an alleged father; a person named as the father of a child born out-of-wedlock but whose paternity has not been established.

"Reasonable cost" means, as it pertains to health care coverage, available through employers, unions, or other groups without regard to service delivery mechanism.

"Recipient" means a person receiving public assistance.

~~*"Responsible parent"* means a person required under law to support a dependent child or the child's caretaker.~~

"Service" or *"service of process"* means the delivery to or leaving of, in a manner prescribed by state statute, an administrative or court order giving the absent ~~responsible~~ parent reasonable notice of the action being taken against him and affording the person an opportunity to be heard regarding the matter.

"Summary of facts" means a written statement of facts outlining the actions taken by the department on a case which has been appealed.

"Supplemental Security Income" means a program administered by the federal government which guarantees a minimum income to persons who meet the requirement of aged, blind, or disabled.

PART II.
GENERAL INFORMATION.

Article 1.
Services.

§ 2.1. Services provided.

A. Child support enforcement services shall be provided as a group to ADC, ADC/FC, and non-ADC clients. Courts and other state IV-D agencies may apply for location-only services. Medicaid only clients shall be provided services to establish or enforce medical support and may, at their request, receive full services.

B. Child support enforcement services shall include the following services which may involve administrative or court action:

1. Location of absent ~~responsible~~ parents, their employers, or their sources of income;

2. Establishment of paternity;

3. Establishment or modification of child support obligations, including the responsibility to provide health ~~care~~ *insurance* coverage;

4. Enforcement of child support *and medical support* obligations, both administratively and judicially determined; and

5. Collection and disbursement of child support payments, regardless of whether the obligation is legally established.

§ 2.2. Eligibility for services.

A. Individuals residing in Virginia who receive ADC, ADC/FC, or Medicaid only assistance are automatically eligible for child support services.

1. ADC and ADC/FC applicants and recipients must accept child support services as a condition of eligibility for public assistance unless the local social service agency determines that good cause exists for not accepting these services.

2. Medicaid only applicants and recipients must accept medical support and paternity establishment services as a condition of eligibility for Medicaid unless the local social services agency determines that good cause exists for not accepting these services.

3. The department shall suspend action on a child support case in which the local social service agency has determined that good cause exists for not cooperating with the department in its pursuit of child support.

4. The department shall continue to provide child support services to a custodial parent when the ADC, ADC/FC, or Medicaid only case closes.

a. The department shall provide these services without requiring a formal application.

b. The department shall continue to provide these services until the custodial parent states in writing that the services are no longer wanted unless the closure of the child support case is contrary to state or federal law.

B. Individuals residing in Virginia or having a legal residence in Virginia who do not receive ADC, ADC/FC, or Medicaid only assistance must make an application for child support services as a condition of eligibility for those services with the exception that an application is not required for cases transferred from the courts to the department on or after October 1, 1985. For such cases the payee shall be deemed as having executed an authorization to seek or enforce a support obligation with the department unless the payee specifically indicates that the department's services are not desired.

1. The child for whom child support is being requested must be under 18 years of age, unless:

a. There is a court order specifying that support continue until a later age, or

b. The child is handicapped, or

c. The services being requested are for a child support obligation which existed prior to the child's 18th birthday.

2. If the child for whom support is being sought is under 18 years of age, the applicant must be the parent or ~~legal~~ *physical* guardian of the child and the child must reside with the applicant.

C. Individuals residing outside of Virginia shall be eligible for child support services upon a request for services from the IV-D agency in the state in which they reside.

D. Courts and other state IV-D agencies are eligible for location only services.

Article 2.
Department as Payee.

§ 2.3. Assignment of rights.

A. Assignment of child support rights to the Commonwealth is automatic by operation of law with receipt of ADC and ADC/FC assistance and continues after the public assistance case closes unless the client requests in writing that the services be terminated.

B. Assignment of medical support rights to the Commonwealth is automatic by operation of law with receipt of Medicaid only assistance and continues after the public assistance case closes unless the client requests in writing that the service be terminated.

§ 2.4. Authorization to seek or enforce a child support

obligation.

Persons receiving child support services shall give the department written authorization to seek or enforce support on behalf of the child or spouse and child.

§ 2.5. Special conditions regarding receipt of ADC or ADC/FC.

A. Receipt of ADC or ADC/FC assistance creates a debt to the Commonwealth.

B. If a debt is owed to the Commonwealth due to the receipt of ADC or ADC/FC assistance, the department shall apply amounts collected for past due child support toward this debt unless the court order stipulates otherwise.

C. Money received from tax intercept shall be applied, in total, toward the ADC or ADC/FC debt.

Article 3.
Application and Case Assessment and Prioritization.

§ 2.6. Application fees.

The application fee for child support services is $1.00 for nonpublic assistance clients. The department shall pay this fee on behalf of such applicants for child support enforcement services.

§ 2.7. Application process.

A. The department shall make applications accessible to the public and shall include with each application information describing child support enforcement services, the custodial parent's rights and responsibilities, the absent ~~responsible~~ parent's rights, and payment distribution policies.

1. The department shall provide an application on the day an individual requests the application when the request is made in person.

2. The department shall send applications within five working days of the date a written or telephone request for an application is received.

B. The department shall provide ADC, ADC/FC, and Medicaid-only recipients with the above information, the rights and responsibilities of custodial parents, the absent ~~responsible~~ parent's rights and general distribution policies within five working days of receiving the referral from a local social service agency.

C. The department shall, within two calendar days of the date of application from a nonpublic assistance recipient or the date a referral of a public assistance recipient is received, establish a case record, and within 20 calendar days, obtain the information needed to locate the absent ~~responsible~~ parent, initiate verification of information, if appropriate, and gather all relevant facts and documents.

§ 2.8. Case assessment and priorization.

A. Case assessment.

The department shall (i) assess the case information to determine if sufficient information to establish or enforce a child support obligation is available and verified and (ii) attempt to obtain additional case information if the information is not sufficient and (iii) verify case information which is not verified.

B. Case prioritization.

1. The department shall give priority to cases which contain any of the following on the absent ~~responsible~~ parent or putative father:

a. Verified, current, residential address; or

b. Current employer; or

c. Last known residential address or last known employer if the information is less than three years old; or

d. Social security number and date of birth.

2. The department shall give low priority but shall review periodically cases in which:

a. There is not adequate identifying or other information to meet requirements for submittal for location, or

b. The absent ~~responsible~~ parent receives supplemental security income or public assistance.

§ 2.9. Service of process.

Service is necessary when child support obligations are established either administratively or through court action and, in some instances, when actions to enforce the obligation are taken.

A. The methods of service of process required by law vary with the action being taken and include individual personal service, substituted service, posted service, certified mail, and regular mail.

B. The department shall use diligent efforts to serve process. Diligent efforts to serve process shall include:

1. When the method of service of process used to notify an absent parent of an administrative action is not successful and the address of the absent ~~responsible~~ parent is known and verified, the department shall exhaust every method of service allowed by law.

2. When the method of service of process used to notify an absent parent of court action is not successful and the address of the absent parent is known and verified, the department shall provide the sheriff or process server with additional information about the absent parent's address.

3. When the method of service of process is not successful after the department has exhausted all methods of service allowed or has provided the sheriff or process server with an additional information, the department shall repeat its attempts to serve process at least quarterly.

§ 2.10. Costs associated with the provision of child support services.

A. The department may not require custodial parents to pay the costs associated with the provision of child support services.

B. The putative father shall pay the costs associated with the determination of paternity if he is ordered by a court to pay these costs.

PART III.
LOCATION.

§ 3.1. The department shall provide location services (i) whenever the location of absent ~~responsible~~ parents or their employers is needed in order to establish or enforce a child support obligation and (ii) when there is sufficient identifying information available to the department to access location sources.

§ 3.2. Location sources.

Whenever location services are provided, the department shall access all necessary locate sources. Locate sources include but are not limited to:

1. Local public and private sources.

2. State Parent Locator Services.

3. Electronic Parent Locator Network.

4. Central Interstate Registry.

5. Federal Parent Locator Service.

6. Parents, friends, and other personal sources.

§ 3.3. Location time requirements.

A. The department shall access all appropriate location sources within 75 calendar days of receipt of the application for child support services or the referral of a public assistance recipient if the department determines that such services are needed and quarterly thereafter if the location attempts are unsuccessful.

B. The department shall review at least quarterly those cases in which previous attempts to locate absent ~~responsible~~ parents or sources of income or assets have failed, but adequate identifying and other information exists to meet requirements for submittal for location.

C. The department shall provide location services immediately if new information is received which may aid in location.

D. When the custodial parent resides in Virginia, the department shall utilize the Federal Parent Locator Service at least annually when other location attempts have failed.

E. When another state requests location services from the department, the department shall follow the time requirements described in the Code of Federal Regulations, Title 45, part 303, § 303.7.

PART IV.
ESTABLISHING CHILD SUPPORT OBLIGATIONS.

Article 1.
Paternity Establishment.

§ 4.1. Establishing paternity.

In order for the department to establish a child support obligation and to enforce and collect child support payments from a putative father, the father must be determined to be legally responsible for the support of the child. In situations in which a putative father has not been legally determined to be the father of the child, paternity must be established before a child support obligation can be administratively ordered or court ordered.

1. The department shall obtain a sworn statement(s) from the custodial parent acknowledging the paternity of the child or children for whom child support is sought.

2. Based on this sworn statement, the department shall attempt to locate the putative father, if necessary, according to the locate time requirements described in Part III above.

3. Once the putative father is located, the department shall contact him to determine if he is willing to sign a sworn statement voluntarily acknowledging paternity or to voluntarily submit to blood testing to determine paternity.

a. The department shall advise the putative father verbally and in writing of his rights and responsibilities regarding child support prior to obtaining a sworn statement of paternity.

b. A putative father who signs a sworn statement of paternity along with an acknowledgement from the mother or who, through genetic blood testing, is

affirmed by at least a 98% probability to be the father of the child is responsible for the financial support of the child or children.

4. When the putative father does not sign a sworn statement of paternity or does not voluntarily submit to blood testing or the blood test shows less than a 98% probability of paternity, the department shall petition the court for a paternity determination when there is sufficient evidence to do so.

5. Within 90 calendar days of locating the putative father, the department shall:

a. Obtain a sworn acknowledgement of paternity or arrange for voluntary blood testing, or

b. File a petition with the court for paternity establishment.

6. In any case where more than one putative father has been identified, the department shall pursue paternity for all putative fathers.

7. The department shall track all cases in which paternity must be established to assure that, in all cases where the putative father is located, paternity is established or the putative father excluded within one year of the child reaching six months of age or within one year of petitioning the court for paternity, whichever occurs later.

§ 4.2. Establishing paternity in interstate cases.

The department shall establish, if possible, the paternity of children who do not reside in Virginia when the putative father resides in Virginia and a request for such services is received from another state IV-D agency.

Article 2.
Administrative Support Orders.

§ 4.3. Administrative establishment of a child support obligation.

The department has statutory authority to establish child support obligations through noncourt ordered legally enforceable administrative means. These administrative obligations have the same force and effect as a support obligation established by the court.

A. The amount of child support that is owed and the frequency with which it is paid must be established before the payment of child support can be enforced.

B. The administrative order shall be called the Administrative Support Order.

C. The department shall use administrative rather than judicial means to establish the child support obligation whenever possible.

D. The department shall use administrative means to establish a temporary child support obligation when judicial determinations of support are pending due to custody and visitation issues.

E. Within 90 calendar days of locating the absent ~~responsible~~ parent, or of establishing paternity the department shall attempt to either ensure that a child support obligation is established or shall diligently attempt to complete the service of process necessary for an obligation to be ordered.

F. When a court dismisses a petition for a support order without prejudice or an administrative hearings officer overrules an administrative support action, the department shall examine the reasons for the dismissal or overruling and determine when or if it would be appropriate to seek an order in the future.

G. The child support obligation is established when an Administrative Support Order has been served and the 10-day appeal period for the administrative order has elapsed.

~~H. The department shall modify the obligation when new information is received necessitating a change.~~

~~I. The department shall modify the amount of the obligation for future child support payments only.~~

§ 4.4. Determining the amount of the child support obligation.

A. The obligation shall include:

1. Frequency with which the current amount owed is to be paid,

2. Current amount owed,

3. Public assistance debt, if any, and

4. Unpaid past due child support, if any.

B. Financial statements.

1. The department shall use financial statements obtained from the absent ~~responsible~~ parent and the custodial parent to determine the amount of the child support obligation. *When financial statements are not provided, the department may use financial information obtained from other sources such as, but not limited to, the Virginia Employment Commission.*

2. The absent ~~responsible~~ parent and custodial parent shall complete financial statements upon demand by the department ~~and annually thereafter~~ . Such responsible parties shall certify under penalty of perjury the correctness of the statement.

3. If the custodial parent is a recipient of public

assistance, the department shall use the information obtained through the ADC or ADC/FC eligibility process to meet the financial statement requirement.

4. The department shall define the type of financial information which shall be required based on § 63.1-274.5 of the Code of Virginia which is incorporated by reference.

5. A custodial parent who is not a responsible parent of the child for whom child support is being sought shall not be required to complete a financial statement.

6. The department shall obtain financial statements from both absent ~~responsible~~ parents when the custodial parent is not ~~a~~ responsible ~~parent~~ *for the support* of the child.

~~C. When an absent parent is responsible for the support of children receiving ADC or ADC/FC assistance, the department shall initially base the amount of the obligation on the amount of ADC or ADC/FC paid on behalf of the responsible parent's dependents.~~

~~1. The department shall change the proposed obligation amount and base it on the child support scale if the absent responsible parent provides financial information during the pendency of an administrative appeal.~~

~~2. If the department receives financial information after the obligation is established, the department shall modify the Administrative Support Order prospectively and shall base the future obligation amount on the child support scale.~~

C. Default obligation.

~~D.~~ When the absent parent ~~is responsible for the support of children not receiving ADC or ADC/FC and provides~~ *does not provide* a financial statement *and financial information cannot be obtained from other sources* ~~, the department shall base the amount of the obligation on the child support scale.~~

~~1. If the responsible parent does not provide a financial statement~~ and there is no court order and no previously issued administrative order, the department shall issue a default Administrative Support Order.

1. The default administrative order shall be based on the USDA estimated annual family expenditures on raising a child in the urban south in combination with the Virginia adjusted gross income and shall be revised yearly.

2. ~~The~~ *In situations where an obligation is not being established to assess a current obligation, but is assessing past public assistance debt only, the* default administrative order shall be based on the amount of public assistance ~~that would be~~ paid on behalf of the absent ~~responsible~~ parent's dependents ~~if they were eligible for ADC assistance~~ .

3. Within 30 days of establishing a default administrative obligation, the department shall petition the court for a modification of the obligation based on the absent parent's ability to pay.

~~E.~~ *D.* The department shall determine the amount to be paid monthly toward a child support debt *or arrearage* when the obligation is administratively ordered and when a court ordered obligation for support does not specify the amount to be paid toward the debt *or arrearage* . The monthly payment for *a child support debt or* arrears will be $65 or 25% of the current obligation, whichever is greater, and shall not exceed the amount allowed under the Consumer Credit Protection Act.

§ 4.5. Service of the administrative support order.

The department must legally serve the Administrative Support Order on the absent ~~responsible~~ parent or receive a waiver of service from the ~~responsible~~ *absent* parent in order to have an established obligation.

§ 4.6. ~~Health care coverage.~~ *Medical support.*

A. The department shall have the authority to issue orders requiring provisions of ~~health care coverage~~ *medical support services* for the dependent children of absent ~~responsible~~ parents if the coverage is available at reasonable cost as defined in § 63.1-250.1 of the Code of Virginia.

B. The absent ~~responsible~~ parent shall provide information regarding ~~health care coverage~~ *medical support services* for his *or her* dependent children, and ~~his~~ spouse or former spouse if applicable, upon request from the department.

C. The absent ~~responsible~~ parent shall provide health care coverage for the child or children if medical insurance is available through his employment. The department may enter an administrative order or seek a judicial order requiring the absent ~~responsible~~ parent's employer to enroll the dependent children in a group health insurance plan or other similar plan providing health ~~care services or~~ *insurance* coverage offered by the employer as provided in § 20-79.3 of the Code of Virginia.

§ 4.7. Child support scale.

A. The department is required to use the Schedule of Monthly Basic Child Support Obligations and procedures in § 20-108.2 of the Code of Virginia in calculating the amount of administrative child support obligations. This section of the Code is incorporated by reference.

B. The department shall call this schedule the child support scale.

C. The department shall use the scale in establishing Administrative Support Orders except ~~in the two situations identified~~ *when a default obligation is established as is defined* in § 4.4 C ~~and D 1~~ .

D. The total child support obligation will be divided between both parents in the same proportion as their individual gross incomes bear to their combined gross income.

E. The department shall consider the following factors in calculating the combined gross income:

1. The absent ~~responsible~~ parent and custodial parent's gross monthly income from all sources with the exception noted in subsection F of this section,

2. The number of children for whom the absent ~~responsible~~ parent and custodial parent share joint legal responsibility,

3. Other current child support obligations which are being paid by the absent or custodial parent,

4. Other dependent children residing with the custodial or absent parent for whom the parents are financially responsible, but who are not included in a child support order,

~~3.~~ *5.* Extraordinary medical and dental expenses which are defined in § 20-108.2 of the Code of Virginia, ~~and~~

~~4.~~ *6.* The custodial parent's work related child care expenses ~~.~~ *, and*

7. Any costs for health insurance coverage as defined in § 63.1-250 of the Code of Virginia when actually paid by a parent.

F. The department may not include benefits from public assistance programs as defined in § 63.1-87, Supplemental Security Income, or child support received in calculating the combined gross income.

§ 4.8. Periodic reviews of the child support obligation.

The amount of the child support obligation is based on the financial situation of both parents. The department or the courts, depending on who issued the order, may modify the amount of the obligation if ~~the parents'~~ *either parent's* situation changes. ~~Either~~ The department *, another state's child support agency* or either parent may initiate a review of the amount of the child support obligation.

A. The department shall initiate a review of each child support obligation as required by federal regulations.

B. Either parent may ~~initiate~~ *request* a review of the child support obligation by providing documentation of a change in circumstances potentially affecting the child support obligation.

C. The department shall modify an administrative obligation when the results of the review indicate a change in the gross income of either parent which is a difference of at least 10% in either parent's gross monthly income or a change in the monthly obligation of at least $25.

D. The department shall modify the obligation for future child support payments only.

~~D.~~ *E.* The department shall petition to modify a court ordered obligation based on *the* criteria *above or on criteria* established by ~~the~~ *a* court.

PART V.
ENFORCING CHILD SUPPORT OBLIGATIONS.

Article 1.
General.

§ 5.1. Enforcement rules.

A. The department shall, whenever possible, administratively enforce compliance with established child support orders including both administrative and court orders.

B. The department shall enforce child support obligations at the time the Administrative Support Order is initially entered through the use of one of the following methods of wage withholdings:

1. Immediate withholding of earnings

2. Voluntary assignment of earnings

C. The department shall enforce child support obligations when the obligation becomes delinquent through the use of one or more of the following administrative enforcement remedies:

1. Mandatory withholding of earnings

2. Liens

3. Orders to withhold and deliver

4. Foreclosure

5. Distraint, seizure, and sale

6. Unemployment compensation benefits intercept

7. Bonds, securities, and guarantees

8. Tax intercept

9. Internal Revenue Service full collection service

10. Credit bureau reporting

11. Enforcement remedies for federal employees.

D. The department shall attempt to enforce current and delinquent child support payments through administrative means before petitioning the court for enforcement action unless it determines that court action is more appropriate.

E. The department shall take any appropriate enforcement action, unless service of process is necessary, within no more than 30 calendar days of identifying a deliquency or of locating that absent ~~responsible~~ parent, whichever occurs later, except income withholding and federal and state income tax refund offset.

F. The department shall take appropriate enforcement action if service of process is necessary within 60 calendar days of identifying a delinquency or of locating the absent ~~responsible~~ parent, whichever occurs later.

G. The department shall take appropriate enforcement action within the above timeframes to enforce health ~~care~~ *insurance* coverage.

H. When an enforcement action is unsuccessful, the department shall examine the reason(s) and determine when it would be appropriate to take an enforcement action in the future. The department shall take further enforcement action at a time and in a manner determined appropriate by department staff.

§ 5.2. Withholding of earnings rules.

A. The department may issue a withholding of earnings order against all earnings except those exempted from garnishment under federal and state law.

B. The amount of money withheld from earnings may not be more than the amount allowed under the Consumer Credit Protection Act. (§ 34-29 of the Code of Virginia)

C. The department must legally serve the wage withholding order on the absent ~~responsible~~ parent or receive a waiver of service from the individual.

D. The department shall modify the withholding of earnings order only if there is a change in the amount of the current support ~~or~~ , past due debt *or arrears* .

E. The department shall release the withholding of earnings order only if one of the following occurs:

1. The current support obligation terminates and any past due debt ~~is~~ *or arrears are* paid in full;

2. Only a past due debt ~~is~~ *or arrears are* owed and it is paid in full;

3. The whereabouts of the child or child and caretaker become unknown;

4. Bankruptcy laws require release; or

5. A nonpublic assistance client no longer wants the services of the department.

Article 2.
Immediate and Voluntary Withholding of Earnings.

§ 5.3. General.

The Administrative Support Order shall include a requirement for immediate withholding of the child support obligation from the absent ~~responsible~~ parent's earnings. The custodial parent and absent ~~responsible~~ parent may choose a voluntary assignment of earnings as an alternate arrangement for payment of child support.

§ 5.4. Immediate withholding of earnings.

The Administrative Support Order shall include a requirement for immediate withholding of the child support obligation from the absent ~~responsible~~ parent's earnings unless the absent ~~responsible~~ parent and the department, on behalf of the custodial parent, agree to an alternative arrangement, or good cause is shown.

§ 5.5. Voluntary withholding of earnings.

A. Voluntary withholding of earnings is also called voluntary assignment of earnings.

B. The custodial parent and absent ~~responsible~~ parent may choose a voluntary assignment of earnings at the time the obligation is established as an alternate to immediate withholding of earnings for payment of child support.

C. The department may initiate a voluntary assignment of earnings when it is the most expeditious means of enforcing a wage withholding.

D. The absent ~~responsible~~ parent may not choose a voluntary assignment of earnings as an alternative to mandatory withholding of earnings after enforcement action has been initiated.

Article 3.
Other Enforcement Remedies.

The department shall have the authority to administratively collect delinquent child support payments from absent ~~responsible~~ parents. These are called enforcement remedies.

§ 5.6. Mandatory withholding of earnings.

The department shall send a Mandatory Withholding of Earnings order to an employer requiring the deduction of the child support obligation from the absent ~~responsible~~ parent's earnings under the following circumstances:

1. When a payment is delinquent in an amount equal to or exceeding one month's child support obligation, or

2. When the custodial parent requests that withholding begin regardless of whether *a debt is owed or* support payments are in arrears.

§ 5.7. Liens.

A. The department may file a lien on the real or personal property of the absent ~~responsible~~ parent when there is a support debt *or arrears* .

B. Upon receipt of a support order from a jurisdiction outside of Virginia, the department may immediately file a lien.

C. The lien of the department shall have the priority of a secured creditor.

D. The lien of the department shall be subordinate to the lien of any prior mortgagee.

E. The lien shall be released when the child support debt *or arrears* has been paid in full.

§ 5.8. Orders to withhold and deliver.

A. The department may use orders to withhold and deliver to collect assets such as bank accounts, trust funds, stocks, bonds, and other types of financial holdings when there is a support debt *or arrears* .

B. The department shall release the order to withhold when the order cannot be served on the absent ~~responsible~~ parent.

C. The department shall release the order to deliver when:

1. The debt *or arrearage* on the order is paid, or

2. The absent ~~responsible~~ parent makes satisfactory alternate arrangements for paying the full amount of the debt *or arrears* .

§ 5.9. Distraint, seizure, and sale.

A. The department may use distraint, seizure, and sale against the real or personal property of an absent ~~responsible~~ parent when there is a support debt *or arrearage* .

B. The director of the division shall give final approval for the use of distraint, seizure, and sale.

§ 5.10. Unemployment compensation benefits intercept.

A. The department may intercept unemployment compensation benefits when there is a support debt *or arrears* .

B. The department may, with the consent of the absent ~~responsible~~ parent, intercept unemployment compensation benefits when there is not a support debt.

C. The department may intercept unemployment compensation benefits paid by the Commonwealth to an absent ~~responsible~~ parent who lives out of state.

D. The department shall intercept the amount of benefits allowed by the Virginia Employment Commission.

§ 5.11. Bonds, securities, and guarantees.

The department shall use administrative bonds, securities, and guarantees as an enforcement action only if the amount of the delinquency exceeds $1,000 and

1. After all other enforcement actions fail, or

2. When no other enforcement actions are feasible.

§ 5.12. Tax intercept.

A. The department shall intercept state and federal income tax refunds and shall apply these moneys, in whole or in part, first to any debt to the Commonwealth and second to delinquent child support obligations.

B. The Virginia Department of Taxation prescribes rules for interception of state tax refunds and notification to the person whose tax refund is being intercepted.

1. The department may retain moneys up to the amount owed on the due date of the finalization notice from the department to the Virginia Department of Taxation.

2. The department may intercept state tax refunds when the delinquent amount equals at least $25.

3. The department may not disburse the intercepted taxes if the absent ~~responsible~~ parent has appealed the intercept action and the appeal is pending.

4. The department shall issue a refund to the absent ~~responsible~~ parent when one of the following occurs:

a. The intercept was made in error.

b. The absent ~~responsible~~ parent pays the delinquent amount in full after the Department of Taxation has been notified of the delinquency and before the tax refund is intercepted.

c. Either or both federal and state tax refunds are intercepted, the total amount intercepted is more than the amount of the delinquency at the time that notification of the tax intercept was sent to the Department of Taxation, and the absent ~~responsible~~

parent does not agree to allow the department to apply the excess funds to any delinquency that accrued after certification for tax intercept.

C. The Internal Revenue Service has prescribed rules regarding the interception of federal tax refunds. Part 45, §§ 302.60 and 303.72 of the Code of Federal Regulations are incorporated by reference in this regulation.

Article 4.
Federal Enforcement Remedies.

In addition to state administrative enforcement remedies, the department shall use federal enforcement remedies to enforce child support obligations.

§ 5.13. Internal Revenue Service full collection service.

A. The department may ask the Internal Revenue Service to collect delinquent child support payments when all reasonable efforts to collect past due child support payments have been made but have not been successful.

B. The department shall make this request through the federal Office of Child Support Enforcement.

§ 5.14. Enforcement remedies to be used against federal employees.

A. The department may apply its enforcement remedies against United States military and civilian active and retired personnel.

B. When enforcement under Virginia law is not possible, the department may use (i) Mandatory Military Allotments and (ii) Involuntary Child Support Allotments for Public Health Services Employees to enforce child support obligations of active military personnel and public health services employees.

1. For the purposes of these two enforcement actions, delinquency shall be defined as failure of the absent ~~responsible~~ parent to make child support payments equal to the amount due for two months.

2. The amount of money withheld from these wages shall be up to the amount allowed under the Consumer Credit Protection Act.

PART VI.
ADMINISTRATIVE APPEALS.

Actions to establish and enforce child support obligations administratively may be appealed according to the following rules.

§ 6.1. Validity of the appeal.

A. The department shall determine the validity of an appeal.

1. The appeal must be in writing.

2. The appeal must be received within 10 working days of service when personally delivered.

3. If mailed, the postmark must be no later than 10 working days from the date of service of the notice of proposed action.

B. The only exception to this shall be appeals of federal and state tax intercepts. The absent ~~responsible~~ parent shall have 30 days to appeal a tax intercept notice to the department.

§ 6.2. General rules.

A. The appeal shall be heard by a hearings officer.

1. The hearings officer shall hold the hearing in the district office where the custodial parent resides unless another location is requested by the absent ~~responsible~~ parent and it complies with § 63.1-267.1 of the Code of Virginia.

2. The absent ~~responsible~~ parent and the custodial parent may be represented at the hearing by legal counsel.

3. The absent ~~responsible~~ parent may withdraw the appeal at any time.

4. The hearings officer shall accept a request for a continuance from the absent ~~responsible~~ parent or the custodial parent if:

a. The request is made in writing at least five working days prior to the hearing, and

b. The request is for not more than a 10-day continuance.

B. The hearings officer shall notify the absent ~~responsible~~ parent and custodial parent of the date and time of the hearing and of the disposition of the hearing in accordance with § 63.1-267.1 of the Code of Virginia.

C. Prior to the hearing, the hearings officer shall send the absent ~~responsible~~ parent and the custodial parent a copy of the Summary of Facts prepared by the district office.

D. The hearings officer shall provide the absent ~~responsible~~ parent and the custodial parent with a copy of the hearing decision either at the time of the hearing or no later than 45 days from the date the appeal request was first received by the department.

E. The hearings officer shall notify the absent ~~responsible~~ parent and the custodial parent in writing by certified mail if the appeal is determined to be abandoned because the absent ~~responsible~~ parent did not appear at

the hearing.

F. The absent ~~responsible~~ parent or the custodial parent may appeal the hearings officer's decision to the juvenile and domestic relations district court within 10 calendar days of receipt of the hearings officer's decision. An appeal of a tax intercept must be made to the circuit court within 30 days of the date of the hearings officer's decision.

§ 6.3. Appeal of enforcement actions.

A. The absent ~~responsible~~ parent may appeal the actions of the department to enforce a support obligation only under the following conditions:

1. For withholding of earnings; liens; distraint, seizure, and sale; and unemployment compensation benefits intercept the appeal shall be based only on a mistake of fact.

2. For orders to withhold and deliver the appeal shall be based only on (i) a mistake of fact or (ii) whether the funds to be withheld are exempt by law from garnishment.

3. Federal and state tax intercepts may be appealed based only on (i) a mistake of fact or (ii) the validity of the claim.

B. A mistake of fact is based on:

1. An error in the identity of the absent ~~responsible~~ parent, or

2. An error in the amount of current support or past due support.

§ 6.4. Appeal of federal enforcement remedies.

Actions to enforce child support payments through federal enforcement remedies may not be appealed through the Department of Social Services. Absent ~~responsible~~ parents shall appeal these actions to the federal agency which took the action.

PART VII.
INTERSTATE RESPONSIBILITIES.

When the absent ~~responsible~~ parent and the custodial parent reside in different states, cooperation between these states is necessary.

§ 7.1. Cooperation with other state IV-D agencies.

A. The department shall provide the same services to other state IV-D cases that it provides to its own cases with the following conditions:

1. The request for services must be in writing.

2. The request for services must list the specific services needed.

B. The department shall request in writing the services of other state IV-D agencies when the custodial parent resides in Virginia, but the absent ~~responsible~~ parent resides in another state.

C. Other department responsibilities in providing services to other state IV-D cases and obtaining services from other state IV-D agencies are defined in Part 45, § 303.7 of the Code of Federal Regulations and §§ 63.1-274.6 and 20-88.22 of the Code of Virginia. These regulations are incorporated by reference here.

§ 7.2. Central registry.

A. The department shall manage the flow of interstate correspondence through a Central Registry located in the division's central office. Correspondence will be handled according to the rules established by the state and federal regulations cited by reference above.

B. The Central Registry shall act as the Uniform Reciprocal Enforcement of Support Act State Information Agent required by § 20-88.22 of the Code of Virginia.

PART VIII.
CONFIDENTIALITY AND EXCHANGE OF INFORMATION.

Article 1.
Information Collected by the Department.

§ 8.1. Information collected from state, county, and city offices.

A. State, county, and city offices and agencies shall provide the department with information about absent ~~responsible~~ parents.

B. The department shall use this information to locate and collect child support payments from absent ~~responsible~~ parents.

§ 8.2. Subpoena of financial information.

The department may subpoena financial records from a person, firm, corporation, association, political subdivision, or state agency to corroborate the existence of assets of the absent ~~responsible~~ parent or the custodial parent identified by the Internal Revenue Service.

Article 2.
Information Released by the Department.

§ 8.3. Agencies to whom the department releases information.

A. The department may release information on absent ~~responsible~~ *or custodial* parents to courts and other state

child support agencies *for the purpose of establishing or enforcing a child support order* .

B. The department shall release information concerning the absent ~~responsible~~ parent to consumer credit agencies upon their request.

~~C. The department may release information concerning custodial parents to courts and other state IV-D agencies as necessary to collect child support on their behalf.~~

~~D.~~ *C.* The department shall ~~obtain permission from the absent responsible parent or the custodial parent prior to providing~~ *provide* information on ~~that person~~ *the absent or custodial parent* to an entity other than the ones listed above *with the written permission of that parent* .

~~E.~~ *D.* The department shall release information concerning custodial parents' and absent ~~responsible~~ parents' medical support payments and medical support orders to the Department of Medical Assistance Services.

§ 8.4. Release of information to and from the Internal Revenue Service.

A. The department may not release information provided by the Internal Revenue Service to anyone outside of the department with the following exceptions:

1. The department may release the information to local social service agencies and the courts, but the source of the information may not be released.

2. The department may release information provided by the Internal Revenue Service if that information is verified by a source independent of the IRS.

B. The division director, or a designee, may release information on absent ~~responsible~~ parents to the Internal Revenue Service.

§ 8.5. Request for information from the general public.

The department shall answer requests for information from the general public within five working days of receipt of the request or less as federal and state law may require.

§ 8.6. Requests for information from absent ~~responsible~~ parents and ~~the~~ custodial parents.

A. The department shall release, upon request from the absent ~~responsible~~ parent or custodial parent, copies of court orders, administrative orders, enforcement actions, ~~and~~ fiscal records , *and financial information used to calculate the obligation. If both parents are absent, financial information will not be released to the other parent* .

B. The department shall release to the absent ~~responsible~~ parent and to the custodial parent personal information contained in the case record which pertains to the individual requesting the information with one exception. The department may not release medical or psychological information for which the physician providing the information has stated the individual should not have access.

C. The absent ~~responsible~~ parent and the custodial parent may correct, challenge, or explain the personal information which pertains to that individual *and may challenge the financial information of the other parent* .

D. The department shall charge a fee for copying case record information. The department shall base the fee on the cost of copying the material.

§ 8.7. Release of health care information.

The department shall provide specific third party liability information to the Department of Medical Assistance Services in order for that agency to pursue the absent ~~responsible~~ parent's medical provider for any Medicaid funds expended for his dependents who are receiving ADC or ADC/FC or who are Medicaid-only clients.

A. The department shall release health ~~care~~ *insurance* coverage information on ADC, ADC/FC, and Medicaid only cases to the Department of Medical Assistance Services as prescribed in the cooperative agreement between the department and that agency.

B. The department shall release health ~~care~~ *insurance* coverage information on ADC, ADC/FC, and Medicaid only cases to other state child support agencies upon their request.

C. The department shall release information on health ~~care~~ *insurance* coverage for nonpublic assistance cases only with the consent of the custodial parent.

PART IX.
RIGHTS AND RESPONSIBILITIES OF THE CUSTODIAL PARENT AND OF THE DEPARTMENT.

Article 1.
Custodial Parent's Rights and Responsibilities.

Throughout this regulation rights and responsibilities of the custodial parents are mentioned in general terms. This section of the regulation does not abridge those rights and responsibilities; it adds to them.

§ 9.1. Custodial parents rights.

A. The department shall give the custodial parent prior notice of major decisions about the child support case.

B. The department shall periodically inform the custodial parent of the progress of the case.

C. The department shall provide the custodial parent with copies of appropriate notices as identified in this regulation.

D. The department shall advise custodial parents who receive ADC of the following rights:

1. The $50 disregard payments, and

2. Eligibility for continued Medicaid coverage when ADC is no longer received.

E. The department shall advise parents who receive ADC, ADC/FC, and Medicaid only of their eligibility for continued child support services when public assistance is no longer received.

F. The department shall inform all non-ADC or ADC/FC clients at the time of application for services of the effect of past receipt of ADC or ADC/FC on the collection of child support payments.

§ 9.2. Custodial parent's responsibilities.

A. Custodial parents must give full and complete information, if known, regarding the absent responsible parent's name, address, social security number, current employment, and employment history and provide new information when learned.

B. Custodial parents must inform the department of any public assistance which was received in the past on behalf of the parent and children.

C. Custodial parents must promptly (i) inform the department of any divorce actions or court actions to establish a child support order, (ii) send to the department copies of any legal documents pertaining to divorce, support, or custody, and (iii) inform the department of any changes in custody or plans for reconciliation with the absent responsible parent.

D. Custodial parents must notify the department if an attorney is hired to handle a child support matter.

E. Custodial parents must notify the department immediately of any change in their financial circumstances.

F. Custodial parents must notify the department in writing regarding any change of their address or name. When possible, the custodial parent shall give this notification 30 days in advance.

Article 2.
Department's Rights and Responsibilities.

§ 9.3. Department's rights.

A. The department shall decide, in a manner consistent with state and federal requirements, the best way to handle a child support case.

B. The department shall decide when to close a case based on federal requirements and the criteria in Part XI.

§ 9.4. Department's responsibilities.

A. The department shall act in a manner consistent with the best interests of the child.

B. The department shall establish a priority system for providing services which will ensure that services are provided in a timely manner.

C. The department shall keep custodial parents advised about the progress of the child support cases and shall include custodial parents in major decisions made about the handling of the child support case.

PART X.
PROCESSING SUPPORT PAYMENTS.

Article 1.
Child Support and Medical Support Payments.

§ 10.1. Disbursement of payments.

A. An absent ~~responsible~~ parent may have multiple child support obligations.

1. Each case shall receive full payment of the current obligation when possible.

2. If the absent ~~responsible~~ parent's disposable earnings do not cover the full payment for each current support order, the department shall prorate the amount withheld among all orders.

B. Current support obligations shall be satisfied before satisfying a past due debt *or arrears* .

C. The method by which child support and medical support payments are disbursed is governed by Part 45, §§ 302.51 and 302.52 of the Code of Federal Regulations which are incorporated by reference.

Article 2.
Payment Recovery.

§ 10.2. Bad checks.

A. When a payment made by an employer or absent ~~responsible~~ parent is not honored upon presentation to the bank on which it was drawn, the department shall first demand payment from the employer or absent ~~responsible~~ parent.

B. If the employer or absent ~~responsible~~ parent does not comply with the demand and the custodial parent is not an ADC or ADC/FC recipient, the department shall recover the payment from the custodial parent according

to the methods described in § 10.4.

C. The department shall concurrently take enforcement action against the absent parent or legal action against the employer.

D. If a check received from a custodial parent is not honored upon presentation to the bank upon which it was drawn, the department shall demand payment from the custodial parent.

§ 10.3. Erroneous/duplicate disbursements.

A. When the department sends the custodial parent a payment in error or a duplicate payment, the department shall first demand payment from the custodial parent.

B. If the custodial parent is not an ADC or ADC/FC recipient and does not comply with the demand, the department shall recover the amount of the payment according to the methods described in § 10.4.

§ 10.4. Methods of payment recovery from the custodial parent.

A. If the custodial parent is not an ADC or ADC/FC recipient, the department shall:

1. Intercept and retain payments for *a* past due debt *or arrearage* .

2. Retain 10% of the current support payment.

3. Retain the lesser of the balance due or 100% of any intercepted funds.

4. Retain the lesser of the balance due or funds seized from bank accounts.

B. If the custodial parent is an ADC or ADC/FC recipient, the division shall notify the Division of Benefit Programs when an erroneous or duplicate payment has been retained by the client.

PART XI.
CASE CLOSURE.

§ 11.1. General rules.

A. The department shall terminate child support enforcement services when one of the criteria defined in the Code of Federal Regulations, Title 45, § 303.11 is met.

B. Sixty calendar days prior to closing a case, the department shall notify the custodial parent of its intent to close the case and shall give the reason for the case closure with the exceptions noted in the Code of Federal Regulations, Title 45, § 303.11. The department shall not close the case if the custodial parent supplies additional case information.

C. The department shall continue to provide collection and disbursement services until alternate arrangement for these services has been made.

D. The department shall reopen a closed case if the custodial parent requests the case be reopened because there is a change in circumstance which could lead to the establishment or enforcement of a child support obligation.

E. The department shall purge all closed case records three years after the case is closed pursuant to the Code of Federal Regulations, Title 45, part 74, subpart D.

PART XII.
COST RECOVERY.

Article 1.
General.

§ 12.1. Recovery of fees.

The department shall assess and recover from the absent ~~responsible~~ parent using any mechanism provided in Chapter 13 of Title 63.1:

1. Attorney's fees,

2. Genetic blood testing fees, and

3. Intercept programs' costs.

§ 12.2. Attorney's fees.

A. Attorney fees shall not exceed the amount allowed court-appointed counsel in the district courts pursuant to subdivision 1 of § 19.2-163.

B. The department shall not recover attorneys' fees or costs in any case in which the absent ~~responsible~~ parent prevails.

§ 12.3. Genetic blood testing.

The department shall set the costs of the genetic blood testing at the rate charged the department by the provider of genetic blood testing services.

§ 12.4. Intercept programs.

The department shall charge the absent ~~responsible~~ parent the rate actually charged the department.

DEPARTMENT OF TRANSPORTATION (COMMONWEALTH TRANSPORTATION BOARD)

Title of Regulation: **VR 385-01-09. Public Participation Guidelines.**

Statutory Authority: § 33.1-12 of the Code of Virginia.

Public Hearing Date: April 13, 1992 - 9:30 a.m.
(See Calendar of Events section
for additional information)

Summary:

The Virginia Department of Transportation is required by the Administrative Process Act (§ 9-6.14:1 et seq. of the Code of Virginia) to establish public participation guidelines. These guidelines are used to notify citizens of the Commonwealth whenever the department enacts or amends a regulation subject to the provisions of the Act so that they may have the chance to comment on the proposed regulation.

These amended regulations simplify and streamline the public participation process by reducing the amount of time which elapses between publication of the public notice and the time when a hearing can be held, by listing the steps to be followed in notification of parties, and by identifying the forms needed by number and name.

The Commonwealth Transportation Board has the authority under § 33.1-12 to review or approve policies of the Department.

VR 385-01-09. Public Participation Guidelines.

§ 1. Authority.

These guidelines are promulgated under the authority granted by Chapter 1.1:1 (§ 9-6.14.1 et seq.) of Title 9 of the Code of Virginia and § 33.1-12 of the Code of Virginia.

§ 2. Purpose.

These guidelines outline the manner in which the Department of ~~Highways and~~ Transportation will encourage the participation of interested parties in the formation and development of regulations *promulgated* under the ~~Virginia~~ Administrative Process Act.

The guidelines are to be used by the department to identify and notify interested parties of the intent to enact *or amend* regulations, and to provide opportunities, including public hearings, for public participation in the formulation of such regulations.

§ 3. Identification of interested parties.

A. ~~Because of the nature of its mission to construct, maintain, and operate facilities included in the state highway system and to assist public transit systems, the department recognizes that all citizens of the Commonwealth have an interest in certain regulatory matters, such as those regarding public use of highway rest areas and waysides. In those instances,~~ *For the purpose of promulgating regulations subject to the Administrative Process Act, the department will regard the public at large as the interested party. This acknowledgement is made in recognition of the fact that department regulations have an impact on Virginia citizens .*

B. When a proposed regulation will be more limited in its effect, the department will identify individuals, corporations, professional or trade associations, public interest groups, and other organizations which express, or have expressed, an interest in the matter under consideration. This *step* will be accomplished in the following ways:

1. Identification of those who have ~~expressed interest to the department~~ *previously notified the department of an interest* in specific regulatory matters ~~in the past~~ .

2. Listing those *parties* who express an interest by writing the Commissioner of the department at ~~1221~~ *1401* East Broad Street, Richmond, Virginia 23219; to any member of the ~~Highway and Transportation Commission~~ *Commonwealth Transportation Board* , or to any of the department's district offices about ~~any particular area or~~ *specific subjects, or those* of general interest.

3. Listing those ~~who are identified by operating divisions of the department~~ *parties whom VDOT operating divisions identify* as interested in participating in the formation of regulations within ~~their~~ *the divisions'* specific areas of responsibility.

C. On occasion, the public interest may best be served by ~~the formation of~~ *obtaining the widest possible public participation; this objective will be accomplished by forming* advisory committees composed of knowledgeable individuals from outside the department ~~, as an additional means of public participation~~ . The Commissioner of the Department of ~~Highways and~~ Transportation will be responsible for determining such instances ~~and for appointment of the~~ *, and will appoint* members of such advisory committees.

§ 4. Notification of interested parties.

~~A. In coordination with the Registrar of Regulations, the department will publish Notices of Intent to develop regulations in general circulation daily newspapers in various metropolitan areas of the Commonwealth at least 30 days before submitting the Notice to the Registrar to begin the formal hearing process.~~

~~B. In matters considered to be of interest to the general public, the department will also prepare news releases and disseminate them to all daily and weekly newspapers, radio, and television stations, and news wire services serving Virginia. The news releases will include, in plain language, information about the subject matter and purpose of regulations under consideration and about provisions for public comment, including the time, date, and place of scheduled public hearings.~~

~~C. Notices of Intent to develop regulations and information about the formal hearing process will be mailed to all parties included on the list maintained by the department at or near the same time the Notices are sent to the Registrar.~~

~~D. Organizations included on the list will be asked to convey information about the Notices of Intent in their newsletters or in other membership communications media which may be available to them.~~

A. Once a decision is made to enact or amend a regulation, the department will submit Form RR01 ("Notice of Intended Regulatory Action") to the Registrar of Regulations for publication in The Virginia Register. After publication of the notice, a 30-day comment period must elapse for interested parties to make comments before the draft of the regulation may be completed.

B. If applicable, the public notification provision contained in subsection A may be supplemented by the following:

1. Sending a copy of the "Notice of Intended Regulatory Action" to those parties previously identified as expressing an interest in the regulation; or

2. Requesting that those business or professional organizations who received copies of the notice publish it in their journals or newsletters.

~~E.~~ *C.* Upon request, the department will provide speakers to discuss regulatory matters with interested private and public sector organizations.

D. The administration of emergency regulations is discussed in § 6 of these guidelines.

§ 5. Opportunities for public participation.

~~Opportunities for public participation will be at two stages:~~

~~A. By the deadline indicated in the Notice of Intent, and prior to initiation of the formal hearing process, the department will receive written suggestions and comments about the proposed regulation. Any written material received after the deadline will be placed on the public hearing docket and considered at the time of the hearing.~~

~~It is to be understood that the department, while considering the information submitted as a result of public participation, reserves the right to prepare the proposed regulation to be considered during the formal regulation adoption process.~~

A. After the 30-day notification period provided for in § 4 has elapsed, the department may decide to hold informal meetings to obtain more specific information from interested parties, depending on the level of interest. The department may also ask those parties who responded to the "Notice of Intended Regulatory Action" to provide written comments, as needed. Any written material received after the deadline specified in the notice will be made part of the public record and will be considered at the time of the hearing.

The department will consider the information submitted as part of the public participation, but reserves the right to prepare the proposed regulation according to its best judgment during the public participation process.

B. The department will hold formal public hearings on all proposed regulations as required by the Administrative Process Act.

1. Public hearings ordinarily will be conducted at the department's central office in Richmond. If the unique nature of a proposed regulation makes it of primary interest in one specific geographic area, the hearing will be held in that area.

2. The hearing will be conducted at a time believed generally convenient for persons and organizations most directly affected by the issue under consideration.

3. The department will make suitable arrangements for responsible officials to attend the hearing, to discuss the proposed regulations and its purpose, and to respond to questions.

4. ~~At least 60 days before a public hearing, the department will make available at its central office in Richmond and at each of its nine district offices a notice of the hearing, a clear statement of the purpose of the proposed regulation, and other written explanatory material which may have been prepared, for public review and copying.~~ *The department will submit a "Notice of Comment Period"(Form RR02) and a "Proposed Action on Regulations" (Form RR03) to the Registrar for publication in The Virginia Register.*

Form RR03 will be accompanied by the regulation and a brief summary explaining the regulation or amendment in a general way. Form RR02 will include the following information: (i) statement of the basis, purpose, substance, issues, and estimated impact of the regulation; (ii) statement of the date, time and place of the hearing at which the regulation will be considered; (iii) reference of the department's legal authority to act; (iv) the name, address, and phone number of the individual to contact for further information.

The notice of opportunity for oral or written submittals shall be published in a newspaper of general circulation published at the state capital, plus any other newspapers in localities affected by the regulation. Press releases and other media may also

be used by district offices or divisions to publicize the proposed action and opportunity for comment. If the department wishes, it may request publication of the statement of basis, purpose, substance, issues, and estimated impact in one or more newspapers.

Publication in The Virginia Register or newspapers shall be made at least sixty days in advance of the last date prescribed in the notice for such submittals. If a hearing is required by law, it may be held at any time before or after expiration of the sixty-day period specified for publication of the meeting notice in The Virginia Register or state newspapers.

5. Provision will be made for submission of written statements and other exhibits in place of, or in addition to, oral statements at the public hearings. This opportunity will be extended to both those present at the hearing and to those who are unable or who do not desire to attend the hearing.

6. All records of written or oral communications, notices, or summaries, including agency action thereon, shall be retained by the department as matters of public record.

§ 6. Emergency regulations.

Emergency regulations shall be promulgated according to the provisions of the § 9-6.14:9 of the Administrative Process Act.

! ~~6.~~ *§ 7. Effective date of guidelines.*

These guidelines will become effective ~~November 1, 1984~~ *as provided for by § 9-6.14:9.3 of the Code of Virginia .*

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.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

REGISTRAR'S NOTICE: The amendments to these regulations are excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 3 of the Code of Virginia, which excludes regulations that consist only of changes in style or form or corrections of technical errors, and § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

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Due to the length of VR 460-02-2.2100 and VR 460-02-2.6100, only the amended pages of the regulations and a summary are being published. The full text of the regulations is available for public inspection at the Office of the Registrar of Regulations and the Department of Medical Assistance Services. The full text of the additional regulations is being published.

Title of Regulations: **State Plan for Medical Assistance Relating to Federal Mandates Resulting from OBRA 90.**
VR 460-01-17. Medically Needy and Qualified Medicare Beneficiaries.
VR 460-01-33. Hearings for Applicants and Recipients.
VR 460-01-68. Prohibition Against Reassignment of Provider Claims.
VR 460-02-2.2100. Groups Covered and Agencies Responsible for Eligibility Determination.
VR 460-02-2.6100. Eligibility Conditions and Requirements.
VR 460-03-2.6101. Income Eligibility Levels.
VR 460-03-2.6113. Section 1924 Provisions.
VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).
VR 460-02-4.1410. Criteria for Nursing Home Preadmission Screening: Medicaid Eligible Individuals and All Mentally Ill and Mentally Retarded Individuals At Risk of Institutionalization.

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

Effective Date: March 11, 1992.

Summary:

The purpose of this action is to amend the Plan for Medical Assistance concerning federal mandates contained in OBRA '90. The issues concern new eligibility groups, provider billing and reimbursement requirements, and preadmission screening.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90), by modifying Title XIX of the Social Security Act, required a number of changes in the State Plan for Medical Assistance. The sections of the Plan affected by this action are: preprint pages, Attachments 2.2 A, 2.6 A, Supplements 1 & 13 to Attachment 2.6 A, Attachments 3.1 A and B and Supplement 1, Attachment 4.22 A, and Supplement to Attachment 4.19 D.

1. New eligibility Groups.

a. Pregnant Woman's Role in Paternity Determinations: Section 4606 of OBRA 90 amended § 1912(a)(1)(B) of the Social Security Act (the Act) to exempt pregnant women from requirements to cooperate in establishing paternity for their unborn children or other living children as a condition of their eligibility for Medicaid.

b. Medicaid Aid to Dependent Children Transition Cases: Section 4716 of OBRA 90 amended § 1925(f) of the Act to prohibit eligibility termination of former ADC families whose Medicaid has been extended for 12 months when the family has not complied with the reporting requirements if the family has good cause for not reporting. Also, § 1925(b)(3)(B) of the Act was amended to prohibit any eligibility termination of families effective earlier than 10 days after the family is sent a notice of the termination.

c. Income Levels for Qualified Medicare Beneficiaries: Section 4501 of OBRA 90 amended § 1905(p)(2)(B) of the Act to increase the mandatory income level for Qualified Medicare Beneficiaries to 100% of the federal poverty income guidelines.

d. Delay in Counting Social Security COLA Increases for QMBs: Section 4501 amended § 1905(p)(1)(B) of the Act to require that the cost of living adjustments (COLAS) in Title II benefits made each January 1 be disregarded until April 1. This provision was designed to protect the Medicaid eligibility of those individuals who would lose eligibility because the COLA caused their income to exceed the income limit.

e. Medicaid Eligibility for Infants under Age 1: Section 4603 amended § 1902(e) of the Act to

require that infants who are born to Medicaid-eligible women remain eligible until their first birthday, so long as the mother remains eligible for Medicaid or would be eligible for Medicaid if she were pregnant.

f. Disregarding German Reparations Payments in Post-Eligibility Treatment of Income: Section 4715 amended § 1902(r)(1) of the Act to require that states disregard from post-eligibility treatment of income any reparation payments made by the Federal Republic of Germany. These payments are made to survivors of the Holocaust.

g. Mandatory Phased-in Coverage of Children up to 100% of Poverty: Section 4601 amended § 1902(a)(10) of the Act to require states to provide Medicaid to all children born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age whose family income is below 100% of the Federal Poverty Income Guidelines.

The Act allows states to impose a resource limit on these individuals; however, Virginia has not chosen to do so because studies of this population have shown that the expected savings are minimal when considered in light of the additional administrative cost of obtaining and evaluating the resource information.

h. Disabled Widows and Widowers: Section 5103 amended § 223(d)(2) of the Act to create a new eligibility group by eliminating the special, more restrictive disability test for disabled widows and widowers, and for disabled surviving divorced spouses. Prior to the enactment of § 5103, these individuals could not be eligible for Title II benefits unless they were unable to perform any gainful activity. This requirement is changed to conform with the standard definition of disability, which requires that individuals be unable to perform any substantially gainful activity.

2. Provider Billing and Reimbursement.

a. Billing for Services of Substitute Physician: Section 4708 amended § 1902(a)(32) of the Act to provide for informal reciprocal arrangements between providers for the treatment of recipients. A provider may bill for those services rendered by another provider to his patient under an informal reciprocal arrangement. The period of time is limited to 14 continuous days in such informal arrangements. In the case of arrangements involving per diem payments or other fee-for-time compensation, the period may be as long as 90 days. The Secretary of the U.S. Department of Health and Human Services may specify longer periods as provided in OBRA 90. The claim must identify the servicing provider in a manner specified by the Secretary.

b. Denial of Payment of Legal Fees for Frivolous Litigation: Section 4801 amended § 1903(i) of the Act to require states to deny reimbursement or compensation to a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the action.

3. Preadmission Screening. Section 4801(b)(2) of OBRA 90 provides that states' preadmission screening programs shall not apply to an individual (i) who is admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital, or (ii) who requires nursing facility services for the condition for which he or she received care in the hospital, or (iii) whose attending physician has certified, before admission to the facility, that he or she is likely to require fewer than 30 days of nursing facility services.

VR 460-01-17. Medically Needy and Qualified Medicare Beneficiaries.

Citation

42 CFR Part 435 and § 435.10,
Subparts G & I
AT-780-90
AT-80-6
AT-80-34
AT-81-4
46 FR 47976 and 1920 of the Act, P.L. 99-509 (§ 9407)

2.6 (b) Medically needy.

All requirements of 42 CFR Part 435, Subparts G and I and § 1920 of the Act are met with respect to the families and individuals to whom the requirements apply. The level of income and resources, expressed in total dollar amounts, that are used as a basis for establishing eligibility under the plan are described in Attachment 2.6-A.

☐ Not applicable. The medically needy are not included in the plan.

Citation

1902(a)(10)(E) and 1905(p) of the Act, P.L. 99-509 (§ 94403), *OBRA 90 1905(p)(2)(D) (§ 4501)*

(c) Qualified Medicare beneficiaries.

All requirements of § 1905(p) of the Act are met with respect to qualified Medicare beneficiaries. The level of income and resources, expressed in total dollar amounts that are used as a basis for establishing eligibility under the plan are described in Attachment 2.6-A.

☐ Not applicable. Qualified Medicare beneficiaries are not included in the plan.

VR 460-01-33. Hearings for Applicants and Recipients.

Citation

42 CFR 431.202
AT-79-29

4.2 Hearings for applicants and recipients.

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

Citation

OBRA 90 (§ 4716)

No termination of coverage under § 1925 shall be effective earlier than 10 days after the date of mailing of the notice required by § 1925(b)(3)(B).

VR 460-01-68. Prohibition Against Reassignment of Provider Claims.

Citation

42 CFR 447.10(c)
AT-79-90
46 FR 42699

4.21 Prohibition against reassignment of provider claims.

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

Citation

OBRA 90
(§ 4708)

In the case of services furnished (during periods that do not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days, or such longer period as the Secretary may provide, in the case of an arrangement involving per diem, or other fee-for-time compensation) by, or incident to, the services of one physician to the patient of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services.

VR 460-02-2.2100. Groups Covered and Agencies Responsible for Eligibility Determination.

VR 460-02-2.2100

Revision: HCFA-PM-87-9 (BERC)
AUGUST, 1987

ATTACHMENT 2.2-A
Page 2
OMB No. 0938-0193

State of Virginia

Agency*	Citation	Groups Covered
IV A	402(a)(22)(A) of the Act, P.L.97-35	c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
IV A	406(h) and 1902(a)(10)(A)(i)(I) of the Act, P.L.98-378 (§20)	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support from August 16, 1984, through September 30, 1988, and meets the requirements of §406(h) of the Act.
IV A	402(a)(37) and 1902(a)(10)(A)(i)(I) of the Act, P.L.98-369 (§§2361 & 2624)	e. Families receiving nine months of work transition per §402(a)(37) of the Act. ___ Families receiving ____ additional months of work transition (not to exceed six months).
IV A	1902(a) of the Act, P.L.99-272 (§12305)	f. Individuals deemed to be receiving AFDC who meet the requirements of §473(b)(1) or (2) for whom an adoption of assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.
IV A	1902(a)(52) & 1925 of the Act, P.L.100-485 OBRA 90 (§4716)	3. Of the 12 months of extended benefits to families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards in accordance with §1925 of the Act. This provision expires on September 30, 1998.
IV A	435.112	4. Families terminated from AFDC solely because of increased earnings or hours of employment, provided the family received AFDC in at least three months during the 6-month period immediately preceding the month in which ineligibility began and provided that one member of the family is employed throughout the period specified in the next sentence. Medicaid is provided for four calendar months beginning with the month AFDC is terminated or if AFDC is terminated retroactively, with the first month in which AFDC was erroneously paid.

* Agency that determines eligibility for coverage.

TN No. 90-28 Approval Date FEB 1, 1991 Effective Date NOV 5, 1990
Supersedes
TN No. _____

VR 460-02-2.2100

Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER, 1986

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State of Virginia

Agency*	Citation	Groups Covered
IV-A	1902(a)(10)(A)(i)(III) and 1905(n) of the Act, P.L.98-369 (§2361) and P.L.99-272 (§9511)	b. A child who is under six years of age who would be eligible for an AFDC cash payment on the basis of the income and resource requirement of the State's approved AFDC plan. The child must be born after-- [X] September 30, 1983; or [ ] _____ (specify optional earlier date)
IV-A	1902(e)(5) of the Act, P.L.99-272 (§9501)	7. A woman who, while pregnant, is eligible for, has applied for, and has received Medicaid under the approved State plan. The woman continues to be eligible, as though she were pregnant, for all pregnancy related and postpartum medical assistance under the plan for a 60-day period which begins on the last day of her pregnancy.
IV	1902(e)(4) of the Act, P.L.98-369 (§2362) OBRA 90 (§4603)	8. A child born to a woman who is eligible for and receiving Medicaid on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible (or would remain if pregnant) and the child remains in the same household as the mother.

* Agency that determines eligibility for coverage.

TN No. 90-28 Approval Date FEB 1, 1991 Effective Date NOV 5, 1990
Supersedes
TN No. _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 2.2 A
page 9a

Agency	Citation(s)		Groups Covered
IV-A	§1634(d)	19a.	Disabled widows or widowers deemed to be eligible for SSI/SSP because they become ineligible for benefits under SSI/SSP due to receipt of a Title II benefit resulting from the change in the definition of disability if: They were receiving SSI/SSP for the month prior to the month they began receiving the Title II benefit: They would continue to be eligible for SSI/SSP if the amount of the Title II benefit were not counted as income and They are not entitled to Medicare Part A.

TN No. 91-14 Approval Date Effective date 7/1/91
Supersedes
TN No. N/A

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

ATTACHMENT 2.2-A
Page 17a
OMB NO.: 0938-0193

Agency*	Citation(s)		Groups Covered
IV-A	1902(a)(10)(A)(ii)(IX) and 1902(1) of the Act, P.L. 99-509 (Sections 9401(a) and (b))	X 13.	The following individuals who are not described in section 1902(a)(10)(A)(i) of the Act whose income level (established at an amount up to 100 percent of the Federal nonfarm poverty line) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and infant or child and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A: (a) Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy) and infants under one year of age (effective April 1, 1987); ___ (b) Children who have attained one year of age but not attained two years of age (effective October 1, 1987); ___ (c) Children who have attained two years of age but not attained three years of age (effective October 1, 1988); ___ (d) Children who have attained three years of age but not attained four years of age (effective October 1, 1989); ___ (e) Children who have attained four years of age but not attained five years of age (effective October 1, 1990). Infants and children covered under Items 13 (a) through (e) above who are receiving inpatient services on the date they reach the maximum age for coverage under the approved plan will continue to be eligible for inpatient services until the end of the stay for which the inpatient services are furnished.
IV-A	1902(1)(1)(D)	XX 13.1	Children born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age whose income level (established at an amount up to 100% of the Federal poverty line) specified in Supplement 1 to Attachment 2.6 A for a family of the same size.

*Agency that determines eligibility for coverage.

TN No._____ Approval Date _____ Effective date_____
Supersedes
TN No._____

VR 460-02-2.2100

Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER, 1986

ATTACHMENT 2.2-A
Page 18
OMB No. 0938-0193

State of Virginia

Agency*	Citation	Groups Covered
IV A	1902(e) of the Act, P.L.99-272 (§9501)	2. Women who, while pregnant, were eligible for, have applied for, and have received Medicaid as medically needy under the approved State plan. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period after the pregnancy ends. The 60-day period begins on the last day of pregnancy.
IV A	1902(a)(10)(C) (ii)(I) of the Act, P.L.97-248 (§137) P.L.100-485	3. Individuals under age 18 who, but for income and resources, would be eligible under §1902(a)(10)()(i) of the Act, including 1902(1)(10)()(i)(V) and 1905(m)(1).
	1902(e)(4) of the Act, P.L.98-369 (§2362) OBRA 90 (§4603)	4. Newborn children born on or after October 1, 1984, to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible (or would remain if pregnant) and the child is a member of the woman's household.
IV A	435.308	X 5. Financially eligible individuals who are not described in §C.3 above and who are under the age of -- X 21 and who meet the covered reasonable classification groups in Attachment 2.2A, Item B7b excluding individuals in ICF/MR facilities. ___ 20 X 19 under age 19 for AFDC related individuals as described in Item A.1. ___ 18
IV A	435.310	
IV A	435.320	
	435.330	___ 6. Caretaker relatives.
IV A	435.322	X 7. Aged individuals.
	435.330	X 8. Blind individuals.
IV A	435.324	X 9. Disabled individuals.
	435.330	

* Agency that determines eligibility for coverage.

TN No. 90-28 Approval Date FEB 10, 1991 Effective Date NOV 5, 1990
Supersedes
TN No. _____

VR 460-02-2.6100. Eligibility Conditions and Requirements.

VR 460-02-2.6100

SOCIAL SECURITY ACT UNDER TITLE XIX

ATTACHMENT 2.6-A
Page 2
OMB No. 0938-0193

State of Virginia

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
435.403 and 1902(b) of the Act, P.L.99-272 (§9529)	4. Is a resident of the State. ___ State has interstate residency agreement with the following states: _X_ State has open agreement(s). ___ Not applicable; no residency requirement.
435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
435.1008	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. ___ Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
433.145 435.604 1912 of the Act, P.L.99-272 (§9503) OBRA 90 (§4606) OBRA 90 (§4402)	6. Is required, (unless the individual is described in §1902(1)(1)(A)) as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met. Also is required, as a condition of Title XIX eligibility, to apply for enrollment in the group health plan in which the individual is otherwise eligible to be enrolled when the state determines it is likely to be cost-effective. This requirements does not affect eligibility of children whose parent(s) fail to meet this provision. ___ Assignment of rights is automatic because of State law.

TN No. 90-28 Approval Date FEB 01, 1991 Effective Date NOV 5, 1990
Supersedes
TN No. _____

VR 460-02-2.6100

Revision: HCFA-PM-87-4 (BERC)
MARCH, 1987

ATTACHMENT 2.6-A
Page 4
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State of Virginia

Citation	Condition or Requirement
435.725 435.733 435.832	B. Post-Eligibility Treatment of Institutionalized Individuals The following amounts are deducted from gross income when computing the application of an individual's or couple's income to the cost of institutional care:
In computing income for purposes of post-eligibility treatment of income, any reparation payments made by the Federal Republic of Germany are disregarded (OBRA 90, §4715)	1. Personal Needs Allowance. a. Aged, blind, disabled-- Individuals $ 30.00 Couples $ 60.00 For the following individuals with greater need--patients in institutions who participate in work programs as part of treatment. The first $75.00 of earning plus 1/2 the remainder, up to a maximum of $190.00 monthly is allowed to be retained for personal needs. b. AFDC related-- Children $ 30.00 Adults $ 30.00 c. Individuals under age 21 covered in this plan as specified in Item b.7 of ATTACHMENT 2.2-A. $ 30.00
435.725 435.733 435.832	2. For maintenance of the non-institutionalized spouse only. The amount must be based on a reasonable assessment of need but must not exceed the highest of-- SSI level $ 407.00 SSP level $ _____ Monthly medically needy level $ _____ Other as follows $ _____

TN No. 90-28
Supersedes
TN No. _____

Approval Date FEB 1, 1991 Effective Date NOV 5, 1990

VR 460-02-2.6100

Revision: HCFA-PM-87-4 (BERC)
MARCH, 1987

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State of Virginia

Citation	Condition or Requirement
1905(p)(1)(c) and (m)(5)(B) of the Act, P.L.99-509 (§9403(b) and (f))	f. In determining countable income for qualified Medicare beneficiaries covered under Section 1902(a)(10)(E) of the Act, the following disregards are applied: XX The disregards of the SSI program. ____ The disregards of the State supplementary payment program, as follows: ____ The disregards of the SSI program except for the following restrictions, applied under the provisions of Section 1902(f) of the Act. Supplement 1 to ATTACHMENT 2.6-A specifies for non-1902(f) and 1902(f) states the income levels for optional categorically needy groups of individuals with incomes up to the Federal nonfarm income poverty line-pregnant women and infants or children covered under §1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under §1902(a)(10)(A)(ii)(X) of the Act--and groups of qualified Medicare beneficiaries covered under §1902(a)(10)(E) of the Act. Supplement 7 to ATTACHMENT 2.6-A specifies for 1902(f) states the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI. ~~Supplement 3 to Attachment 2.6-A contains more restrictive budget methodologies which shall be applied to qualified Medicare beneficiaries.~~
OBRA 90 1905(p)(2)(D) (§4501)	g. In determining under this subsection the monthly income of an individual who is entitled to monthly insurance benefits under Title II for a transition period [as defined in clause ii of 1905(p)(2)(D)], such income shall not include cost of living adjustments in Title II benefits payable for months beginning with December of the previous year.

TN No. 91-11 Approval Date JUN 21, 1991 Effective Date MAY 30, 1991
Supersedes
TN No. _____

VR 460-03-2.6101. Income Eligibility Levels.

A. Income eligibility levels–categorically needy.

1. For AFDC related groups:

No. of Persons	Group I	Group II	Group III
1	$131	$157	$220
2	207	231	294
3	265	291	354
4	322	347	410
5	380	410	488
6	427	458	534
7	482	512	590
8	541	572	650
9	591	623	701
10	647	678	755
Each person above 10	56	56	56

2. For aged, blind, disabled groups: the SSI income levels.

3. For individuals meeting the requirements of §§ 435.231 and 435.232, the income level is 300% of the SSI payment level for an individual.

B. Income eligibility levels–optional categorically needy groups with incomes up to federal poverty line.

1. Pregnant women, infants, and children. The levels for determining income eligibility for groups of pregnant women, infants, and children under the provisions of § 1902(1)(2) of the Act are as follows:

Based on 133%, and updated annually, of the official federal nonfarm income poverty line:

Size of Family Unit	Poverty Guideline
1	$ 8,805
2	11,811
3	14,816
4	17,822
5	20,828
6	23,834
7	26,840
8	29,846
Each additional person	3,006

2. Aged and disabled individuals. The levels for determining income eligibility for groups of aged disabled individuals under the provisions of § 1902(m)(4) of the Act are as follows:

Based on....% of the official federal nonfarm income poverty line:

Not covered.

B1. Income eligibility levels–categorically needy groups with incomes up to federal poverty line.

1. Children who have attained age 6 but have not attained age 19 born after September 30, 1983. The levels for determining income eligibility for groups of children under the provisions of § 1902(1)(1)(D) of the Act are as follows:

Based on 100 percent of the official federal nonfarm income proverty line:

Size of Family Unit	*Poverty Guideline*
1	*$6,620*
2	*8,880*
3	*11,140*
4	*13,400*
5	*15,660*
6	*17,920*
7	*20,160*
8	*22,440*

C. Income eligibility levels–optional group of qualified Medicare beneficiaries with incomes up to federal poverty line.

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of § 1905(p)(2)(A) of the Act are as follows:

Based on 100%, and updated annually, of the office federal nonfarm income poverty line:

D. Income eligibility levels–mandatory group of qualified disabled and working individuals with incomes up to federal poverty line.

The levels for determining income eligibility for groups of qualified disabled and working individuals under the provisions of § 1905(s) of the Act are as follows:

Based on 200%, and updated annually, of the official federal nonfarm income poverty level:

Size of Family Unit	Poverty Guideline

1	$ 13,240
2	17,760

E. Income levels–medically needy.

☒ Applicable to all groups

Applicable to:

1. Family size.

2. Net income level protected for maintenance.

3. Net income level for persons living in rural areas.

☐ urban only

☒ urban and rural

	Group I	Group II	Group III
1	$2,600	$3,000	$3,900
2	3,400	3,700	4,800
3	3,900	4,300	5,300
4	4,400	4,800	5,800
5	4,900	5,300	6,300
6	5,400	5,800	6,800
7	5,900	6,300	7,300
8	6,500	6,900	7,800
9	7,100	7,500	8,500
10	7,800	8,200	9,100
For each additional person, add:	600	600	600

Size of Family Unit	Poverty Guideline
1	$ 6,620
2	8,880

Grouping of Localities

Group I

Counties	Counties	Counties	Cities
Accomack	Highland	Sussex	Lynchburg
Alleghany	Isle of Wight	Tazewell	Martinsville
Amelia	James City	Washington	Newport News
Amherst	King George	Westmoreland	Norfolk
Appomattox	King and Queen	Wise	Petersburg
Bath	King William	Wythe	Portsmouth
Bedford	Lancaster	York	Radford
Bland	Lee		Richmond
Botetourt	Louisa	Cities	Roanoke
Brunswick	Lunenberg		Salem
Buchanan	Madison	Bristol	Staunton
Buckingham	Matthews	Buena Vista	Virginia Beach
Campbell	Mecklenburg	Clifton Forge	Williamsburg
Caroline	Middlesex	Danville	Winchester
Carroll	Nelson	Emporia	***
Charles City	New Kent	Franklin	Group III
Charlotte	Northhampton	Galax	
Clarke	Northhumberland	Norton	Cities
Craig	Nottoway	Poquoson	
Culpeper	Orange	Suffolk	Arlington
Cumberland	Page	***	Fairfax
Dickenson	Patrick	Group II	Montgomery
Dinwiddie	Pittsylvania		Prince William
Essex	Powhatan	Albemarle	
Fauquier	Prince Edward	Augusta	Cities
Floyd	Prince George	Chesterfield	Alexandria
Fluvanna	Pulaski	Henrico	Charlottesville
Franklin	Rappahannock	Loudoun	Colonial Heights
Frederick	Richmond	Roanoke	Fairfax
Giles	Rockbridge	Rockingham	Falls Church
Gloucester	Russell	Warren	Fredericksburg
Goochland	Scott		Hampton
Grayson	Shenandoah	Cities	Manassas
Greene	Smyth	Chesapeake	Manassas Park
Greensville	Southampton	Covington	Waynesboro
Halifax	Spotsylvania	Harrisonburg	
Hanover	Stafford	Hopewell	
Henry	Surry	Lexington	

VR 460-03-2.6113. Section 1924 Provisions.

§ 1924 Provisions

a. Income and resource eligibility policies used to determine eligibility for institutionalized spouses who have spouses living in the community are consistent with

§ 1924.

b. In the determination of resource eligibility the state resource standard is $12,000 adjusted annually in accordance with § 1924(g).

c. An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible under title XIX of the Social Security Act, per § 1924(c)(3)(C), where the state determines that denial of eligibility on the basis of having excess resources would work an undue hardship.

OBRA 90 (§ 4714)

d. State community property laws do not apply for purposes of post-eligibility treatment of income.

OBRA 90 (§ 4714)

e. The spousal share is determined at the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse.

VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).

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. 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.

C. As mandated by the Omnibus Budget Reconciliation Act of 1990, effective November 5, 1990, reimbursement of legal expenses for frivolous litigation shall be denied if the action is initiated on or after November 5, 1990. Frivolous litigation is any action initiated by the nursing facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action.

§ 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 reimbursement 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 reimbursement (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 reimbursement 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 460-02-4.1410. Criteria for Nursing Home Preadmission Screening: Medicaid Eligible Individuals and All Mentally Ill and Mentally Retarded Individuals At Risk of Institutionalization.

§ 1. Definitions.

"Active treatment for mental illness" means the implementation of an individual treatment that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness which necessitates 24-hour supervision by trained mental health personnel. The active treatment plan is developed under and supervised by a physician and provided by a physician and other qualified mental health professionals.

"Active treatment for mental retardation" means a continuous program for each client, which includes aggressive, consistent implementation of specialized and generic training, treatment, health, and related services that are directed towards (i) the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and (ii) the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program. The active treatment plan shall be developed and supervised by an interdisciplinary team that represents areas that are relevant to identifying the client's needs and to designing programs that meet the client's needs.

"Community services board (CSB)" means the local agency responsible for local mental health, mental retardation, and substance abuse services. Boards function as service providers, client advocates, and community educators.

"Cost effectiveness" means the determination that the Medicaid expenditure for an individual receiving home and community-based care services is equal to or less than the Medicaid expenditure would be for that individual to receive nursing home care.

"DMAS-95 form" means the assessment tool used by nursing home preadmission screening committees and utilization review staff to assess an individual's medical, functional and social status, and document the justificati- for the need for nursing facility care and the appropriate

level of care.

"Home and Community-Based Care Services" means Medicaid-funded long-term care services offered to Medicaid eligible elderly or physically disabled individuals in a home or community-based care setting in lieu of nursing home placement. These services must be preauthorized by either a nursing home preadmission screening committee or DMAS utilization review staff as a part of the nursing home preadmission screening process.

"Level I assessment" means the screening process, whether done by the nursing home preadmission screening committees, private practitioners or some other entity contracted with DMAS, to identify those individuals who are in need of nursing facility care and who have a known or suspected diagnosis of mental illness or mental retardation or related condition.

"Level II assessment process" means the evaluation of the need for active treatment for those individuals who are identified in Level I as needing nursing facility care and as having a condition of mental illness or mental retardation. For individuals who are Medicaid eligible or expected to become Medicaid eligible within 180 days, the CSBs or other entity authorized to complete Level II assessments will submit the required assessments to the state mental health or mental retardation authority which will decide whether or not active treatment is indicated. For private pay individuals, the nursing facility shall submit copies of the required evaluations to the state mental health or mental retardation authority. The state mental health or mental retardation authority shall decide whether or not active treatment is indicated and shall inform the nursing facility of the decision. Nursing facilities are prohibited from admitting any individual who is mentally ill or mentally retarded unless it has been determined by the Level II assessment that the individual requires the level of services provided by a nursing facility and that the active treatment needs of the individual can be appropriately provided in the nursing facility.

"Mental illness" means the existence of a current primary or secondary diagnosis of a mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM IIIR), limited to schizophrenic, paranoid, major affective, schizoaffective disorders, and atypical psychosis, and does not include a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, severe physical illness, terminal illness or acute physical illness which requires convalescence care.

"Mental retardation and related conditions" means the existence of a level of retardation (mild, moderate, severe and profound) as defined in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983). This definition states that "Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." The provisions of this section also apply to persons with "related conditions," meaning severe, chronic disabilities that meet all of the following conditions:

° They are attributable to cerebral palsy or epilepsy or any other condition including autism, other than mental illness, found to be closely related to mental retardation because the related condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for those persons.

° They are manifested before the person reaches age 22.

° They are likely to continue indefinitely.

° They result in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

"MI/MR Supplemental Assessment" means the assessment form utilized by the nursing home preadmission screening committees in conjunction with the DMAS-95 form to identify those individuals who have been assessed to need nursing facility care and who have a known or suspected diagnosis of mental illness or mental retardation or a related condition.

"Nursing home preadmission screening committee" means either a local committee organized by the local health director or a committee established in a hospital setting for the purpose of determining whether an individual meets nursing facility criteria. Those committees organized by the local health director shall be composed, at a minimum, of a physician, nurse, and social worker. The nurse and physician (both of whom must be licensed or eligible to be licensed) shall be employed by the local health department, and the social worker shall be employed from the adult services section of the local department of social services or the local health department. The committee, at the discretion of the local health director, may include representatives of other agencies which provide community services to aged and disabled individuals. Hospital committees shall be composed of a social worker or discharge planner and physician. If the discharge planner is not a nurse, collaboration with a registered nurse who is knowledgeable about the individual's medical needs shall be required prior to completion of the screening process. A mental health professional from the local community services board may also serve on the committee.

"Nursing Home Preadmission Screening Program" means a process to: (i) evaluate the medical, nursing, developmental, psychological, and social needs of each individual believed to be in need of nursing home

admission; (ii) analyze what specific services the individual needs; and (iii) evaluate whether a service or a combination of existing community services is available to meet the individual's needs. An essential part of the assessment process is determining the level of care required by applying existing criteria for skilled and intermediate nursing home care.

"Plan of care" means the weekly schedule of services, home and community-based care and other formal and informal services, developed to meet the assessed needs of the individual in order to avoid nursing home placement. The plan of care shall ensure the safety, health and welfare of the individual in order for home and community-based care services to be authorized.

"Private pay individuals" means persons who are not Medicaid eligible or are not expected to be Medicaid eligible within 180 days of admission to a nursing facility.

"State mental health or mental retardation authority" means the designated representative(s) of the Department of Mental Health, Mental Retardation and Substance Abuse Services who shall make active treatment decisions.

§ 2. Persons subject to nursing home preadmission screening and identification of conditions of mental illness and mental retardation.

A. As a condition of a nursing facility's Medicaid participation, all persons applying for admission to it shall be screened to determine whether they meet the criteria for nursing facility placement and whether conditions of mental illness and mental retardation or related conditions exist. Nursing facilities are responsible for ensuring that applicants for admission who have a known or suspected case of mental illness, mental retardation or related conditions are not admitted until an evaluation of their condition and need for active treatment has been made under the screening process.

B. Beginning April 1, 1990, nursing facility residents shall be identified for conditions of mental illness or mental retardation through annual review.

C. Preadmission screening need not provide for determinations in the case of a readmission to a nursing facility of an individual who, after being admitted to the nursing facility, is transferred for care in a hospital. In addition, preadmission screening shall not apply to the admission to a nursing facility of an individual who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, who requires nursing facility services for the condition for which he received care in the hospital, and whose attending physician certified before admission to the facility that he is likely to require fewer than 30 days of nursing facility services.

§ 3. Preadmission screening assessment process.

A. Level I assessment.

1. For individuals who are Medicaid eligible or are expected to become Medicaid eligible within 180 days, the nursing home preadmission screening committee or other entity contracted by DMAS will complete the initial screening assessment to determine (i) the need for nursing facility services and (ii) whether or not the individual has a known or suspected diagnosis of mental illness or mental retardation or a related condition. The DMAS-95 form and the MI/MR Supplemental Assessment will be used by the screening committees in making Level I assessments. Persons identified as possibly mentally ill or mentally retarded shall be referred for further diagnostic evaluation (Level II assessment) performed by the local community services board (CSB) or other entity contracted to complete Level II assessment.

2. For private pay individuals applying to enter a nursing facility, it will be the responsibility of the nursing facility to determine (i) the need for nursing facility services and (ii) whether or not the individual is or may be mentally ill or mentally retarded or has a related condition. Persons identified as mentally ill or mentally retarded shall be referred to their private practitioners for further diagnostic evaluation.

B. Level II assessment.

1. For individuals who are Medicaid eligible or expected to be Medicaid eligible within 180 days, the entity completing the Level II assessment will refer any individual screened by Level I assessment who meets the nursing facility criteria and is suspected of having conditions of mental illness or mental retardation or related conditions for a Level II assessment. The CSB or other entity responsible for completing the Level II assessment will determine the individual's need for active treatment and the appropriate placement if active treatment is indicated. The criteria used in making a decision about appropriate placement are not, in any way, to be affected by the availability of placement alternatives. The state mental health or mental retardation authority shall decide whether or not active treatment is indicated, based on the Level II assessment recommendation. If active treatment for mental retardation or mental illness is required, the CSB or other responsible entity will arrange for the appropriate services to be provided.

2. For those private pay individuals, the nursing facility will refer any individual suspected of having conditions of mental illness or mental retardation to a private practitioner to determine if there is a need for active treatment and the appropriate placement if active treatment is indicated. The criteria used in making a decision about appropriate placement are not, in any way, to be affected by the availability of placement alternatives. The nursing facility shall

submit copies of the required evaluations to the Department of Mental Health, Mental Retardation and Substance Abuse Services which shall decide whether or not active treatment is indicated, based on the private practitioner's recommendation. If active treatment for mental retardation or mental illness is required, the Department of Mental Health, Mental Retardation and Substance Abuse Services shall notify the nursing facility of the determination of appropriate placement for that individual.

3. Nursing facilities are prohibited from admitting any individual who is mentally ill or mentally retarded unless it has been determined by the Level II assessment that the individual requires the level of services provided by a nursing facility and that the active treatment needs of the individual can be appropriately provided in the nursing facility.

§ 4. Nursing home preadmission screening authorization.

At the completion of the nursing home preadmission screening assessment and evaluation, the nursing home preadmission screening committee, or DMAS utilization review staff or other authorized entity shall authorize the appropriate service level for the individual screened. If an individual disagrees with a determination of either the preadmission screening committee or the state mental health or mental retardation authority, he has the right to appeal under the applicable appeal process.

A. Referrals for services not required.

When it is determined that the individual does not need nursing facility care and is not in need of any other community services, the committee will not authorize any services for the individual.

B. Referrals to non-Medicaid-funded community services.

When it is determined that the individual does not need nursing facility care but requires some services in order to be adequately maintained in the community, the committee shall make referrals to the appropriate agency and assure that the individual and family understand how to access those community services.

C. Home and community-based care authorization.

When it is determined that the individual does need the type of care found in a nursing facility but could be maintained appropriately in the community with home and community-based care services, the committee shall give the individual the choice of nursing home placement or home and community-based care services. In order to make the determination that home and community based care services can appropriately maintain the individual in the community, the nursing home preadmission screening committee shall: (i) develop a plan of care for home and community-based care, (ii) determine the cost effectiveness of this plan of care, (iii) offer the individual a choice of home and community-based care providers, (iv) ensure provider availability to render services and make referrals for service initiation.

D. Nursing home authorization.

When the assessment process has been completed and it is determined that nursing facility care is needed and home and community-based care services are not considered an appropriate alternative, the authorization for nursing home placement may be made. The screening committee shall make referrals for appropriate placement.

E. Referrals to state facilities for the mentally ill or mentally retarded.

When the screening committee, CSB and state mental health or mental retardation authority determine that the individual meets nursing facility criteria and requires active treatment in a state facility for mental illness, mental retardation or related conditions, nursing home placement shall not be authorized. Instead, the CSB will initiate placement proceedings.

COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

910 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-3591

January 23, 1992

Mr. Bruce Kozlowski, Commissioner
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RE: Preprinted Pages: VR 460-01-17; 460-01-33; and 460-01-68
Attachments: VR 460-02-2.2100; 460-02-6100; 460-02-3.1100; 460-02-3.1200; 460-02-4.2210; and 460-02-1410;
Supplements: VR 460-03-2,6101; 460-03-2,6113; and 460-03-4.1940
Federal Mandates Resulting from OBRA 90.

Dear Mr. Kozlowski:

This will acknowledge receipt of the above-referenced regulations from the Department of Medical Assistance Services.

As required by § 9-6.14:4.1 C.4.(c). of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law.

Sincerely,

Joan W. Smith
Registrar of Regulations

JWS:jbc

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REGISTRAR'S NOTICE: This regulation is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 3 of the Code of Virginia, which excludes regulations that consist only of changes in style or form or corrections of technical errors. The Department of Medical Assistance Services will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **VR 460-03-4.1911. Hospital Appeals of Reimbursement.**

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

Effective Date: March 11, 1992.

Summary:

This technical amendment assigns a separate regulation number to the portion of VR 460-02-4.1910 (inpatient hospital reimbursement methodology) concerning the methodology for appealing hospital reimbursement rates. No changes have been made in the text of the regulation.

VR 460-03-4.1911. Hospital Reimbursement Appeals Process

§ 1. Right to appeal and initial agency decision.

A. Right to appeal.

Any hospital seeking to appeal its prospective payment rate for operating costs related to inpatient care or other allowable costs shall submit a written request to the Department of Medical Assistance Service within 30 days of the date of the letter notifying the hospital of its prospective rate unless permitted to do otherwise under § 5 E. The written request for appeal must contain the information specified in § 1 B. The department shall respond to the hospital's request for additional reimbursement within 30 days or after receipt of any additional documentation requested by the department, whichever is later. Such agency response shall be considered the initial agency determination.

B. Required information.

Any request to appeal the prospective payment rate must specify: (i) the nature of the adjustment sought; (ii) the amount of the adjustment sought; and (iii) current and prospective cost containment efforts, if appropriate.

C. Nonappealable issues.

The following issues will not be subject to appeal: (i) the organization of participating hospitals into peer groups according to location and bedsize and the use of bedsize and the urban/rural distinction as a generally adequate proxy for case mix and wage variations between hospitals in determining reimbursement for inpatient care; (ii) the use of Medicaid and applicable Medicare Principles of Reimbursement to determine reimbursement of costs other than operating costs relating to the provision of inpatient care; (iii) the calculation of the initial group ceilings on allowable operating costs for inpatient care as of July 1, 1982; (iv) the use of the inflation factor identified in the State Plan as the prospective escalator; and (v) durational limitations set forth in the State Plan (the "twenty-one day rule").

D. The rate which may be appealed shall include costs which are for a single cost reporting period only.

E. The hospital shall bear the burden of proof throughout the administrative process.

§ 2. Administrative appeal of adverse initial agency determination.

A. General.

The administrative appeal of an adverse initial agency determination shall be made in accordance with the Virginia Administrative Process Act, § 9-6.14:11 through § 9-6.14:14 of the Code of Virginia as set forth below.

B. The informal proceeding.

1. The hospital shall submit a written request to appeal an adverse initial agency determination in accordance with § 9-6.14:11 of the Code of Virginia within 15 days of the date of the letter transmitting the initial agency determination.

2. The request for an informal conference in accordance with § 9-6.14:11 of the Code of Virginia shall include the following information:

a. The adverse agency action appealed from;

b. A detailed description of the factual data, argument or information the hospital will rely on to challenge the adverse agency decision.

3. The agency shall afford the hospital an opportunity for an informal conference in accordance with § 9-6.14:11 of the Code of Virginia within 45 days of the request.

4. The Director of the Division of Provider Reimbursement of the Department of Medical Assistance Services, or his designee, shall preside over the informal conference. As hearing officer, the director (or his designee) may request such additional documentation or information from the hospital or agency staff as may be necessary in order to render an opinion.

5. After the informal conference, the Director of the Division of Provider Reimbursement, having

considered the criteria for relief set forth in §§ 4 and 5 below, shall take any of the following actions:

a. Notify the provider that its request for relief is denied setting forth the reasons for such denial; or

b. Notify the provider that its appeal has merit and advise it of the agency action which will be taken; or

c. Notify the provider that its request for relief will be granted in part and denied in part setting forth the reasons for the denial in part and the agency action which will be taken to grant relief in part.

6. The decision of the informal hearing officer shall be rendered within 30 days of the conclusion of the informal conference.

§ 3. The formal administrative hearing: procedures.

A. The hospital shall submit its written request for a formal administrative hearing under § 9-6.14:12 of the Code of Virginia within 15 days of the date of the letter transmitting the adverse informal agency decision.

B. At least 21 days prior to the date scheduled for the formal hearing, the hospital shall provide the agency with:

1. Identification of the adverse agency action appealed from; and

2. A summary of the factual data, argument and proof the provider will rely on in connection with its case.

C. The agency shall afford the provider an opportunity for a formal administrative hearing within 45 days of the receipt of the request.

D. The Director of the Department of Medical Assistance Services, or his designee, shall preside over the hearing. Where a designee presides, he shall make recommended findings and a recommended decision to the director. In such instance, the provider shall have an opportunity to file exceptions to the proposed findings and conclusions. In no case shall the designee presiding over the formal administrative hearing be the same individual who presided over the informal appeal.

E. The Director of the Department of Medical Assistance Services shall make the final administrative decision in each case.

F. The decision of the agency shall be rendered within 60 days of the conclusion of the administrative hearing.

§ 4. The formal administrative hearing: necessary demonstration of proof.

A. The hospital shall bear the burden of proof in seeking relief from its prospective payment rate.

B. A hospital seeking additional reimbursement for operating costs relating to the provision of inpatient care shall demonstrate that its operating costs exceed the limitation on operating costs established for its peer group and set forth the reasons for such excess.

C. In determining whether to award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, the Director of the Department of Medical Assistance Services shall consider the following:

1. Whether the hospital has demonstrated that its operating costs are generated by factors generally not shared by other hospitals in its peer group. Such factors may include, but are not limited to, the addition of new and necessary services, changes in case mix, extraordinary circumstances beyond the control of the hospital, and improvements imposed by licensing or accrediting standards.

2. Whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis.

a. In making such a determination, the director or his designee may require that an appellant hospital provide quantitative data, which may be compared to similar data from other hospitals within that hospital's peer group or from other hospitals deemed by the director to be comparable. In making such comparisons, the director may develop operating or financial ratios which are indicators of performance quality in particular areas of hospital operation. A finding that the data or ratios or both of the appellant hospital fall within a range exhibited by the majority of comparable hospitals, may be construed by the director to be evidence that the hospital has taken every reasonable action to contain costs in that particular area. Where applicable, the director may require the hospital to submit to the agency the data it has developed for the Virginia Health Services Cost Review Council. The director may use other data, standards or operating screens acceptable to him. The appellant hospital shall be afforded an opportunity to rebut ratios, standards or comparisons utilized by the director or his designee in accordance with this section.

b. Factors to be considered in determining effective cost containment may include the following:

- Average daily occupancy,
- Average hourly wage,
- FTE's per adjusted occupied bed,
- Nursing salaries per adjusted patient day,
- Average length of stay,
- Average cost per surgical case,
- Cost (salary/nonsalary) per ancillary procedure,
- Average cost (food/nonfood) per meal served,
- Cost (salary/nonsalary) per pharmacy prescription,

- Housekeeping cost per square foot,
- Maintenance cost per square foot,
- Medical records cost per admission,
- Current ratio (current assets to current liabilities),
- Age of receivables,
- Bad debt percentage,
- Inventory turnover,
- Measures of case mix,
- Average cost per pound of laundry.

c. In addition, the director may consider the presence or absence of the following systems and procedures in determining effective cost containment in the hospitals's operation.

- Flexible budgeting system,
- Case mix management systems,
- Cost accounting systems,
- Materials management system,
- Participation in group purchasing arrangements,
- Productivity management systems,
- Cash management programs and procedures,
- Strategic planning and marketing,
- Medical records systems,
- Utilization/peer review systems.

d. Nothing in this provision shall be construed to require a hospital to demonstrate every factor set forth above or to preclude a hospital from demonstrating effective cost containment by using other factors.

The director or his designee may require that an onsite operational review of the hospital be conducted by the department or its designee.

3. Whether the hospital has demonstrated that the Medicaid prospective payment rate it receives to cover operating costs related to inpatient care is insufficient to provide care and service that conforms to applicable state and federal laws, regulations and quality and safety standards.[1]

D. In no event shall the Director of the Department of Medical Assistance Services award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care unless the hospital demonstrates to the satisfaction of the director that the Medicaid rate it receives under the Medicaid prospective payment system is insufficient to ensure Medicaid recipients reasonable access to sufficient inpatient hospital services of adequate quality.[2] In making such demonstration, the hospital shall show that:

1. The current Medicaid prospective payment rate jeopardizes the long-term financial viability of the hospital. Financial jeopardy is presumed to exist if, by providing care to Medicaid recipients at the current Medicaid rate, the hospital can demonstrate that it is, in the aggregate, incurring a marginal loss.[3]

For purposes of this section, marginal loss is the amount by which total variable costs for each patient day exceed the Medicaid payment rate. In calculating marginal loss, the hospital shall compute variable costs at 60% of total inpatient operating costs and fixed costs at 40% of total inpatient operating costs; however, the director may accept a different ratio of fixed and variable operating costs if a hospital is able to demonstrate that a different ratio is appropriate for its particular institution.

Financial jeopardy may also exist if the hospital is incurring a marginal gain but can demonstrate that it has unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospital's long-term financial viability; and

2. The population served by the hospital seeking additional financial relief has no reasonable access to other inpatient hospitals. Reasonable access exists if most individuals served by the hospital seeking financial relief can receive inpatient hospital care within a 30 minute travel time at a total per diem rate which is less to the Department of Medical Assistance Services than the costs which would be incurred by the Department of Medical Assistance Services per patient day were the appellant hospital granted relief.[4]

E. In determining whether to award additional reimbursement to a hospital for reimbursement cost which are other than operating costs related to the provision of inpatient care, the director shall consider Medicaid applicable Medicare rules of reimbursement.

§ 5. Available relief.

A. Any relief granted under §§ 1 through 4 above shall be for one cost reporting period only.

B. Relief for hospitals seeking additional reimbursement for operating costs incurred in the provision of inpatient care shall not exceed the difference between:

1. The cost per allowable Medicaid day arising specifically as a result of circumstances identified in accordance with § 4 (excluding plant and education costs and return on equity capital); and

2. The prospective operating cost per diem, identified in the Medicaid Cost Report and calculated by the Department of Medical Assistance Services.[5]

C. Relief for hospitals seeking additional reimbursement for (i) costs considered as "pass-throughs" under the prospective payment system, or (ii) costs incurred in providing care to a disproportionate number of Medicaid recipients, or (iii) costs incurred in providing extensive neonatal care shall not exceed the difference between the payment made and the actual allowable cost incurred.

D. Any relief awarded under §§ 1 through 4 above shall be effective from the first day of the cost period for which the challenged rate was set. Cost periods for which relief will be afforded are those which begin on or after January 4, 1985. In no case shall this limitation apply to a hospital which noted an appeal of its prospective payment rate for a cost period prior to January 4, 1985.

E. All hospitals for which a cost period began on or after January 4, 1985, but prior to the effective date of these regulations, shall be afforded an opportunity to be heard in accordance with these regulations if the request for appeal set forth in subsection A of § 1 is filed within 90 days of the effective date of these regulations.

§ 6. Catastrophic occurrence.

A. Nothing in §§ 1 through 5 shall be construed to prevent a hospital from seeking additional reimbursement for allowable costs incurred as a consequence of a natural or other catastrophe. Such reimbursement will be paid for the cost period in which such costs were incurred and for cost periods beginning on or after July 1, 1982.

B. In order to receive relief under this section, a hospital shall demonstrate that the catastrophe met the following criteria:

1. One time occurrence;
2. Less that 12 months duration;
3. Could not have been reasonably predicted;
4. Not of an insurable nature;
5. Not covered by federal or state disaster relief;
6. Not a result of malpractice or negligence.

C. Any relief sought under this section must be calculable and auditable.

D. The agency shall pay any relief afforded under this section in a lump sum.

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Footnotes:

[1] See 42 U.S.C. § 1396(a)(13)(A). This provision reflects the Commonwealth's concern that it reimburse only those excess operating costs which are incurred because they are needed to provide adequate care. The Commonwealth recognizes that hospitals may choose to provide more than "just adequate" care and, as a consequence, incur higher costs. In this regard, the Commonwealth notes that "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services... that package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered – not "adequate health care." Alexander v. Choate – U.S. – decided January 9, 1985, 53 U.S. L.W., 4072, 4075.

[2] In Mary Washington Hospital v. Fisher, the court ruled that the Medicaid rate "must be adequate to ensure reasonable access." Mary Washington Hospital v. Fisher, at p. 18. The need to demonstrate that the Medicaid rate is inadequate to ensure recipients reasonable access derives directly from federal law and regulation. In its response to comments on the NPRM published September 30, 1981, HCFA points out Congressional intent regarding the access issue:

The report on H.R. 3982 states the expectation that payment levels for inpatient services will be adequate to assure that a sufficient number of facilities providing a sufficient level of services actively participate in the Medicaid Program to enable all Medicaid beneficiaries to obtain quality inpatient services. This report further states that payments should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals in the state.

46 Fed. Reg. 47970.

[3] The Commonwealth believes that Congressional intent is threatened in situations in which a hospital is incrementally harmed for each additional day a Medicaid patient is treated – and therefore has good cause to consider withdrawal from the Program – and where no alternative is readily available to the patient, should withdrawal occur. Otherwise, although the rate being paid a hospital may be less than that paid by other payors – indeed, less than average cost per day for all patients – it nonetheless equals or exceeds the variable cost per day, and therefore benefits the hospital by offsetting some amount of fixed costs, which it would incur even if the bed occupied by the Medicaid patient were left empty.

It should be emphasized that application of this marginal loss or "incremental harm" concept is a device to assess the potential harm to a hospital continuing to treat Medicaid recipients, and not a mechanism for determining the additional payment due to a successful appellant. As discussed below, once a threat to access has been demonstrated, the Commonwealth may participate in the full average costs associated with the circumstances underlying the appeal.

[4] With regard to the 30 minute travel standard, this requirement is consistent with general health planning criteria regarding acceptable travel time for hospital care.

[5] The Commonwealth recognizes that in cases where circumstances warrant relief beyond the existing payment rate, it may share in the cost associated with those circumstances. This is consistent with existing policy, whereby payment is made on an average per diem basis. The Commonwealth will not reimburse more than its share of fixed costs. Any relief to an appellant hospital will be computed on an occupancy adjusted basis. Relief will be computed using patient days adjusted for the level of occupancy during the period under appeal. In no case will any additional payments made under this rule reflect lengths of stay which exceed the 21 day limit currently in effect.

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DEPARTMENT OF MOTOR VEHICLES

Title of Regulation: **VR 485-10-8401. Public Participaton Guidelines. REPEALED.**

Title of Regulation: **VR 485-10-9101. Public Participation Guidelines for Regulation Development and Promulgation.**

Statutory Authority: §§ 9-6.14:7.1 and 46.2-203 of the Code of Virginia.

Effective Date: March 11, 1992.

Summary:

The Public Participation Guidelines for Regulation Development and Promulgation establish guidelines for receiving input and participation from interested citizens in the development of any regulations which the department proposes. The regulations will repeal and replace the department's existing guidelines. These guidelines include specific procedures for notifying and obtaining input from interested citizens, organizations, and affected groups and describes, in detail, the regulation development procedure. In addition, the regulations more closely comply with changes in the procedures set out in the Administrative Process Act.

VR 485-10-9101. Public Participation Guidelines for Regulation Development and Promulgation.

§ 1. General purpose.

In developing any regulation it proposes, the Department of Motor Vehicles ("department") is committed to soliciting input and comment from interested citizens, professional associations, and industry representatives. Such input and participation will be actively solicited by the department pursuant to the Administrative Process Act, Chapter 1.1:1 (§ 9-6.14:1 et seq.) of Title 9 of the Code of Virginia.

Any person who is interested in participating in the regulation development process should notify the department in writing. Such notification of interest should be sent to the Commissioner, Department of Motor Vehicles, P. O. Box 27412, Richmond, Virginia 23269-0001.

§ 2. Identification of interested parties.

Prior to the development of any regulation, the department will identify persons whom it feels would be interested or affected by the proposal. The methods for identifying interested parties will include, but not be limited to, the following:

1. Obtain annually from the Secretary of the Commonwealth a list of all persons, groups, associations and others who have registered as lobbyists for the annual General Assembly session. This list will be used to identify groups which may be interested in the subject matter of the proposed regulation.

2. Utilize the statewide listing of business, professional, civic and charitable associations and societies in Virginia published by the State Chamber of Commerce to identify additional industry and professional associations which might be interested in the regulation.

3. Utilize internal administration mailing lists of persons, organizations, groups, and agencies that have expressed an interest in advising and assisting in the development of regulations or who have previously raised questions or expressed an interest in the subject matter under consideration pursuant to § 1, or through requests for formal rulings or administrative appeals. At the discretion of each administration, these lists may be maintained on a program specific basis or be of a general interest group. From time to time the lists will be updated to include any new interested parties.

§ 2. Notification of interested parties.

A. Generally.

The department will prepare a Notice of Intended Regulatory Action (Form RR01) ("Notice") prior to the development of any regulation. The notice will identify the subject matter and purpose for the development of the new regulation(s), will state the statutory authority under which they are promulgated, and will specify a time deadline for receipt of responses from persons interested in participating in the development process. The name, address and telephone number of an agency contact will also be included in the notice.

B. Dissemination of notice.

The methods for disseminating the notice to the public will include, but not be limited to, the following:

1. Send notice to individuals or groups identified in § 2 as interested or potentially affected parties.

2. Publish the notice in the Virginia Register of Regulations.

3. Request that industry, professional associations, and other groups to whom the notice is sent publish such notice in newsletters or journals or use any other means available to them to disseminate the notice to their memberships.

4. Invite participation from the general public through the publication of a Notice of Intent in the Richmond Times-Dispatch and, if necessary, in other general newspapers.

5. The notification process delineated in this section does not apply to emergency regulations, which are excluded from the operation of Article 2 (§ 9-6.14:7.1 et seq.) of the Administrative Process Act.

§ 4. Regulation development.

A. Response to notice.

After interested parties have responded to the notice, the department will analyze the level of interest. If sufficient interest exists, the department may schedule informal meetings prior to the development of any regulation to determine the specific areas of interest or concern and to gather factual information relative to the subject matter of the regulation. Form RR06, Notice of Meetings, will be used for this purpose. Alternatively, the department may elect to request that persons who have responded to the notice submit written comments, concerns and suggestions relative to the proposed regulation.

B. Establishment of advisory committee.

When necessary, utilize a core, advisory committee comprised of appropriate department representatives, persons who have previously participated in public proceedings relative to similar subject matters, or selected individuals who responded to a Notice of Intended Regulatory Action, newsletter or special mailing. The committee will discuss the issues and make recommendations which will be considered in drafting regulations. Once the regulations have been developed, the committee will review them and continue to participate during the promulgation process as directed by the Administrative Process Act.

C. Preparation of working draft.

Subsequent to the initial public input on the development of any regulation, the department will develop a working draft of the proposed regulation. In certain instances where the technical nature of the subject matter merits, the department may request that industry or professional groups develop a working draft. A copy of this draft will be furnished to all persons who responded to the notice indicating an interest in the regulation and to those persons participating in the initial comment phase of the development process. Persons to whom a copy of the working draft is furnished will be invited to submit written comments on the draft. If the response warrants, additional informal meetings may be held to discuss the working draft.

D. Submission of proposed regulation submission package.

Upon the conclusion of the development process, the department will prepare a proposed regulation submission package for submission to the office of the Registrar of Regulations. The package will include:

1. Notice of Comment Period (Form RR02) (3 copies);

2. Proposed Regulations Transmittal Sheet (Form RR03) (3 copies);

3. A statement of basis, purpose, substance, issues and impact (2 copies);

4. A summary of the regulation (2 copies);

5. Double-spaced text of the proposed regulation (2 copies); and

6. Reporting forms used in administering the regulation, if any (2 copies).

Once the Registrar receives all the required documents and appropriate number of copies, the proposed regulation and summary will be published in the "Proposed Regulation" section of the Virginia Register.

At the same time that the regulations are filed with the Registrar's Office, the department will file Form RR09, Regulation Review Summary, and a copy of the proposed regulations to the Department of Planning and Budget and to the Governor's office.

The notice of comment period will appear in each issue of the Virginia Register until the public hearing date or 60-day written comments deadline has elapsed, whichever occurs last. The summary provided with the Notice of Comment Period form will be printed in a newspaper of general circulation published in the state capital and, in addition, similarly published in newspapers in localities particularly affected by the proposed regulations.

D. Review of proposed regulation after publication.

1. Agency review. The department will compare the published copy of the regulation with the agency copy. Corrections will be filed with the Registrar.

2. Legislative and gubernatorial review. During the 60-day notice of comment period, 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 the comments will be published in the Virginia Register. The department will respond to the Governor's comments pursuant to § 9-6.14:9.1 of the Code of Virginia.

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 Registrar and the promulgating agency. The department will respond to the objection pursuant to § 9-6.14:9.1 of the Code of Virginia.

E. Final regulations submission package.

When the notice of comment period has elapsed, the department may take action on the proposed regulations, and will again submit for publication the text of the regulation as adopted, explaining any substantial changes in the final regulation, along with an up-to-date basis, purpose, substance, issues and impact statement. A 30-day final adoption period will begin upon publication in the Virginia Register. The package will contain:

1. Final regulation transmittal sheet (Form RR04) (3 copies);

2. Statement of final agency action (2 copies);

3. Explanation of substantial changes;

4. Summary of public comments and agency's responses (2 copies);

5. Summary of regulation;

6. Statement of basis, purpose, substance, issues and impact (2 copies);

7. Double-spaced text of final regulation (2 copies); and

8. Reporting forms used in administering the final regulation, if any.

At the same time that the regulations are filed with the Register's office, the Department of Planning and Budget and the Governor's office will receive copies of the final regulations.

§ 5. Effective date.

The final regulation will become effective 30 days after it is published in the Virginia Register, or a later date, if specified. If there are gubernatorial or legislative objections, the procedures specified in the Administrative Process Act, § 9-6.14:1 et seq. of the Code of Virginia, will be followed.

§ 6. Availability of final regulation.

The department will make available to the public copies of the adopted regulations, together with the summary of the public comments and the department's responses. The Governor's comments and the department's responses will also be available to the public. Copies of the final regulations will be sent to all interested parties who have specifically requested them.

§ 7. Forms.

The forms described herein may change from time to time. Copies of appropriate forms in current use will be attached to these guidelines and will be updated when necessary.

DEPARTMENT OF STATE POLICE

REGISTRAR'S NOTICE: This regulation is excluded from Article 2 of the Administrative Process Act in accordance with § 9-6.14:4.1 C 4(c) of the Code of Virginia, which excludes regulations that are necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation. The Department of State Police will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision.

Title of Regulation: **VR 545-01-1. Motor Carrier Safety Regulations.**

Statutory Authority: § 52.-8.4 of the Code of Virginia.

Effective Date: March 11, 1992.

Summary:

Amendment 2 adopts and incorporates by reference the Procedures for Transportation Workplace Drug Testing Programs promulgated by the U.S. Department of Transportation and found in Part 40 of the Code of Federal Regulations and in effect as of October 1, 1991. Part 40 describes the rules for drug testing in general and procedures for conducting drug urine testing. Amendment 2 also incorporates by reference changes made by the U.S. Department of Transportation, Federal Highway Administration, to Title 49, Code of Federal Regulations (CFR), Parts 390 through 397 promulgated and in effect as of October 1, 1991. These changes included: (i) amending 49 CFR 391.83 (c) which extends the compliance date of Subpart H for foreign-based employees of foreign domiciled carriers for drug use to January 2, 1993; (ii) amending 49 CFR 391.85 by defining nonsuspicion-based post-accident testing. This provides that a commercial vehicle driver involved in a reportable accident and is issued a citation (traffic summons) for a moving traffic violation arising from the accident is all that is needed to trigger a post-accident controlled substance test for that driver under Part 391, Subpart H; (iii) amending 49 CFR 391.93 which requires motor carriers subject to the FHWA's controlled substance testing regulations to begin random and certain mandatory post-accident drug testing of their drivers. This action is necessary to notify motor carriers subject to 49 CFR, Part 391, Subpart H, that the injunction against the FHWA's drug testing program has been dissolved and that random and post-accident testing previously deferred must be implemented. The effective date is November 14, 1991, for motor carriers with 50 or more drivers subject to testing, and on January 1, 1992, for all other motor carriers; (iv) amending 40 CFR Part 396.25 to require motor carriers to ensure that brakes and brake systems of commercial motor vehicles are properly maintained and inspected by appropriate employees. These regulations establish minimum training requirements and qualifications for employees responsible for maintaining and inspecting brake systems. This rule will ensure that brakes on commercial motor vehicles are properly inspected and maintained and is effective January 1, 1991, and must be implemented by January 1, 1992; (v) amending these regulations to more clearly define a

"commercial motor vehicle" in accordance with federal regulations and § 46.2-341.4 of the Code of Virginia contained in the "Virginia Commercial Driver's License Act"–it adds gross combination weight rating and includes the placarding requirement in the hazardous materials definition; (vi) amending these regulations to included the definition of a "reportable accident" as it relates to Motor Carrier Safety Regulations.

VR 545-01-1. Motor Carrier Safety Regulations.

PART I.
DEFINITIONS.

§ 1.1. Definitions.

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

"Commercial motor vehicle" means any self-propelled or towed vehicle used on the highways in interstate or intrastate commerce to transport passengers or property if (i) such vehicle has a gross vehicle weight rating or gross combination weight rating or more than 26,000 pounds, (ii) is designed to transport more than fifteen passengers, *including the driver,* regardless of weight or (iii) is used to transport hazardous materials *in a quantity requiring placards by regulations issued under authority of Article 7 (§ 10.1-1450 et seq.) of Chapter 14 of Title 10.1 of the Code of Virginia, Transportation of Hazardous Materials .*

"Motor carrier" means a common carrier by motor vehicle, a contract carrier by motor vehicle or a private carrier of property by motor vehicle. This term also encompasses any agent, officer, representative or employee who is responsible for hiring, supervision, training, assignment or dispatching of drivers.

"Reportable accident" as it relates to Motor Carrier Safety Regulations means an occurrence involving a commercial motor vehicle engaged in interstate or intrastate operations of a motor carrier who is subject to these regulations resulting in (i) the death of a human being, (ii) bodily injury to a person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident or (iii) total damage to all property aggregating $4,400 or more based upon actual costs or reliable estimates.

"Safety inspections" means the detailed examination of a vehicle for compliance with safety regulations promulgated under § 52-8.4 of the Code of Virginia and includes a determination of the qualifications of the driver and his hours of service.

"Superintendent" means the Superintendent of the Department of State Police of the Commonwealth of Virginia.

"Transport vehicle" means any vehicle owned or leased by a motor carrier used in the transportation of goods or persons.

PART II.
GENERAL INFORMATION AND LEGISLATIVE AUTHORITY.

§ 2.1. Authority for regulation.

A. These regulations are issued under authority of § 52-8.4 of the Code of Virginia, Powers and duties to promulgate regulations; inspection of certain records.

B. Section 52-8.4 of the Code of Virginia mandates that the Superintendent of State Police, with the cooperation of such other agencies of the Commonwealth as may be necessary, shall promulgate regulations pertaining to commercial motor vehicle safety pursuant to the United States Motor Carrier Act of 1984.

C. These regulations, as promulgated, shall be no more restrictive that the applicable provisions of the Federal Motor Carrier Safety Regulations of the United States Department of Transportation.

§ 2.2. Purpose of regulations.

These regulations shall set forth criteria relating to driver, vehicle, and cargo safety inspections with which motor carriers and transport vehicles shall comply.

§ 2.3. Application of regulations.

A. These regulations and those contained in Title 49, Code of Federal Regulations, Parts *40 and* 390 through 397, unless excepted, shall be applicable to all employers, employees, and commercial motor vehicles, which transport property or passengers in interstate and intrastate commerce.

B. These regulations shall not apply to hours worked by any carrier when transporting passengers or property to or from any portion of the Commonwealth for the purpose of providing relief or assistance in case of earthquake, flood, fire, famine, drought, epidemic, pestilence, major loss of utility services or other calamity or disaster. The suspension of the regulation provided for in § 52-8.4 A shall expire if the Secretary of the United States Department of Transportation determines that it is in conflict with the intent of Federal Motor Carrier Safety Regulations.

§ 2.4. Enforcement.

The Department of State Police, together with all other law-enforcement officers of the Commonwealth who have satisfactorily completed forty hours of on-the-job training and a course of instruction as prescribed by the U.S. Department of Transportation, Federal Highway Administration, Office of Motor Carriers, in federal motor

carrier safety regulations, safety inspection procedures, and out-of-service criterial shall enforce the regulations and other requirements promulgated pursuant to § 52-8.4 of the Code of Virginia. Those law enforcement officers certified to enforce the regulations and other requirements promulgated pursuant to § 52-8.4 shall annually receive in-service training in current federal motor carrier safety regulations, safety inspection procedures, and out-of-service criteria.

§ 2.5. Inspection of records.

Any records required to be maintained by motor carriers pursuant to regulations promulgated by the Superintendent under the authority of § 52-8.4 A of the Code of Virginia, shall be open to inspection during a carrier's normal business hours by specially trained members of the Department of State Police designated for that purpose by the Superintendent shall also be authorized, with consent of the owner, operator or agent in charge or with an appropriate warrant obtained under the procedure prescribed in Chapter 24 (§ 19.2-393 et seq.) of Title 19.2 of the Code of Virginia, to go upon the property of motor carriers to verify the accuracy of maintenance records by an inspection of the vehicles to which those records relate.

§ 2.6. Penalties.

Any violation of the provisions of the regulations adopted pursuant to § 52-8.4 of the Code of Virginia, shall constitute a traffic infraction punishable by a fine or not more than $1,000 for the first offense or by a fine of not more than $5,000 for a subsequent offense. Each day of violation shall constitute a separate offense.

PART III.
INCORPORATION BY REFERENCE.

Article 1.
Compliance with Federal Regulations.

§ 3.1. Compliance.

A. Every person and commercial motor vehicle subject to the Motor Carrier Safety Regulations operating in interstate or intrastate commerce within or through the Commonwealth of Virginia shall comply with the Federal Motor Carrier Safety Regulations promulgated by the United States Department of Transportation, Federal Highway Administration, with amendments promulgated and in effect as of October 1, 1991, pursuant to the United States Motor Carrier Safety Act found in Title 49, Code of Federal Regulations (CFR), Parts 390 through 397, which are incorporated in these regulations by reference, with certain exceptions, as set forth below.

B. Those persons required to comply with subsection A shall also comply with Procedures for Transportation Workplace Drug Testing program promulgated by the United States Department of Transportation, with amendments and in effect as of the date in subsection A and found in Title 49 of the Code of Federal Regulations, Part 40, which is incorporated in these regulations by reference as set forth below.

Article 2.
Part 40 - Procedures for Transportation Workplace Drug Testing Programs.

§ 3.2. Drug testing procedures.

Incorporated with no exceptions as it relates to Title 49 of the Code of Federal Regulations, Part 391, Subpart H - Controlled Substance Testing (§ 391.81 et seq.).

Article 3.
Part 390 - General.

§ 3.3. Minimum levels of financial responsibility for motor carriers - § 390.3 (c).

A commercial motor vehicle used wholly in intrastate commerce is not subject to this section unless transporting hazardous materials, hazardous substances or hazardous waste as set forth in Title 49, Code of Federal Regulations, Part 387.3, (b) and (c).

§ 3.4. Exempt intra-city zone - § 390.5.

This term does not include a driver or vehicle used wholly in intrastate commerce.

Article 4.
Part 391 - Qualifications of Drivers.

§ 3.5. Minimum age - § 391.11.

A driver may be 18 years old if operating wholly in intrastate commerce and is not subject to article 7 (§10.1 - 1450 et seq.) of Chapter 14 of Title 10.1 of the Code of Virginia, Regulations Governing the Transportation of Hazardous Materials.

§ 3.6. Investigations and inquiries - § 391.23.

Except as provided in Subpart G of this part, each intrastate motor carrier shall make investigations and inquiries required by paragraphs (1) and (2) of this section with respect to each driver it employs, other than a person who has been a regularly employed driver of the intrastate motor carrier for a continuous period which began before July 9, 1986.

§ 3.7. Resolution of conflicts of medical evaluation - § 391.47.

The Superintendent reserves the right to resolve medical conflicts involving those drivers used wholly in intrastate commerce.

§ 3.8. Waiver of certain physical defects - § 391.49.

A person who is not physically qualified to drive under § 391.41 (b) (1) or (b) (2) or (b) (3) or (b) (10), and is not subject to Article 7 (§ 10.1 - 1450 et seq.) of Chapter 14 of Title 10.1 of the Code of Virginia, Regulations Governing the Transportation of Hazardous Materials, and who is otherwise qualified to drive a property-carrying motor vehicle, may drive a property-carrying motor vehicle in intrastate commerce if granted a waiver by the Superintendent.

§ 3.9. Driver qualification files - § 391.51.

The applicable date referred to in § 391.51 (b) and (c) shall be July 9, 1986, for drivers used wholly in intrastate commerce. The Superintendent's letter granting a waiver of a physical disqualification to an intrastate driver, if a waiver was issued under § 391.49, shall be in the driver quailification files.

§ 3.10. Subpart G - Limited exemptions - § 391.61.

The applicable date referred to in § 391.61 shall be July 9, 1986, for drivers used wholly in intrastate commerce.

§ 3.11. Subpart H - Controlled substance testing - § 391.81 et seq.

Intrastate motor carriers shall implement Subpart H effective November 15, 1991. Ninety days will be allowed for affected intrastate motor carriers to comply.

Article 5.
Part 392 - Driving of Motor Vehicles.

§ 3.12. Driving of motor vehicles.

Incorporated with no exceptions.

Article 6.
Part 393 - Parts and Accessories Necessary for Safe Operation.

§ 3.13. Parts and accessories.

Incorporated with no exceptions.

Article 7.
Part 394 - Notification and Reporting of Accidents.

§ 3.14. Notification and accident reporting.

Intrastate motor carriers and drivers need only comply with § 46.2-371 of the Code of Virginia and Article 11 (§ 46.2-894 et seq.) of Chapter 8 of Title 46.2 of the Code of Virginia.

Article 8.
Part 395 - Hours of Service of Drivers.

§ 3.15. Drivers declared out of service - § 395.13 (a).

Law-enforcement officers of the Department of State Police specifically designated by the Superintendent are authorized to declare a driver out of service and to notify the motor carrier of that declaration, upon finding at the time and place of examination that the driver has violated the out-of-service criteria as set forth in § 395.13 (b).

§ 3.16. Responsibilities of motor carriers - § 395.13 (c) (2).

A motor carrier shall complete the "Motor Carrier's Report of Compliance with this Notice" portion of form S.P. 233-A (Virginia State Police Motor Carrier Safety Inspection) and deliver the copy of the form either personally or by mail to the Department of State Police, Office of Administrative Coordinator, Motor Carrier Safety, at the address specified upon the form within 15 days following the date of the examination. If the motor carrier mails the form, delivery is made on the date it is postmarked.

Article 9.
Part 396 - Inspection, Repair, and Maintenance.

§ 3.17. Inspection of motor vehicles in operation - § 396.9 (a).

Law-enforcement officers of the Department of State Police specifically designated by the Superintendent are authorized to enter upon and perform inspections of motor carrier vehicles in operation.

§ 3.18. Motor vehicles declared "out of service" - § 396.9 (c).

Authorized personnel defined in § 3.17 above shall declare and mark "out of service" any motor vehicle which by reason of its mechanical conditioner or loading would likely cause an accident or a breakdown. An "Out of Service Vehicle" sticker shall be used to mark vehicles "out of service."

§ 3.19. Motor carrier's disposition - § 396.9 (d) (3) (ii).

Motor carriers shall return the completed form S.P. 233 (Virginia State Police Motor Carrier Safety Inspection) to the Department of State Police at the address indicated on the report.

Article 10.
Part 397 - Transportation of Hazardous Materials; Driving and Parking Rules.

§ 3.20. Driving and parking rules - § 397.

Incorporated with no exceptions.

COMMONWEALTH of VIRGINIA

JOAN W. SMITH
REGISTRAR OF REGULATIONS

VIRGINIA CODE COMMISSION
General Assembly Building

910 CAPITOL STREET
RICHMOND, VIRGINIA 23219
(804) 786-3591

January 20, 1992

Colonel W. F. Corvello, Superintendent
Department of State Police
7700 Midlothian Turnpike
Richmond, Virginia

RE: VR 545-01-01 Motor Carrier Safety Regulations

Dear Colonel Corvello:

This will acknowledge receipt of the above-referenced regulations from the Department of State Police.

As required by § 9-6.14:4.1 C.4.(c). of the Code of Virginia, I have determined that these regulations are exempt from the operation of Article 2 of the Administrative Process Act, since they do not differ materially from those required by federal law.

This regulation will be published in the February 10, 1992 issue of the Virginia Register of Regulations and will become effective on March 11, 1992.

Sincerely,

Joan W. Smith

Joan W. Smith
Registrar of Regulations

JWS:jbc

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 Date: March 11, 1992.

Summary:

This regulation continues the options that were added to nine of the General Relief Program components by the emergency regulation published in the March 25, 1991, Virginia Register of Regulations. The options 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.

VR 615-01-36. General Relief (GR) Program - Locality Options.

PART I.
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:

"Agency" means the local department of social services.

"Agency contract" means the local department of social services has an agreement with a pharmacy to provide prescription drugs for recipients of General Relief.

"Assistance for unattached children" means a component of the General Relief Program that can provide assistance to children who would be eligible for Aid to Dependent Children (ADC) if the relationship requirement were met.

"Assistance for unemployed employable individuals" means a component of the General Relief Program that can provide assistance to individuals who are not working but are able to work.

"Assistance for unemployable individuals" means a component of the General Relief Program that can provide assistance to individuals who are unable to work because of physical or mental disability, age or lack of training, illness in the family, or home responsibilities.

"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 of 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. 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 Supplemental Security Income (SSI), who must apply for SSI, or are appealing an SSI decision.

"Maximum for the locality" means the amount of reimbursable assistance applicable to some components based on the agency group. Agencies are placed in one of three groups based on shelter expenses in the area.

"Monthly maximum" means the dollar amount of assistance specified in the General Relief Plan for some components.

"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.

"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.~~

"Rent/house payments" means a subcomponent of the shelter assistance component that can be used to pay housing expenses.

"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 applicable to some components based on the size of the assistance unit and the agency group. Agencies are placed in one of three groups based on shelter expenses in the area.

"Subcomponent" means a part of a component.

"Utility payments" means a subcomponent of the shelter assistance component that can be used to pay for items, such as electricity, oil, water, and natural gas.

PART II.
AVAILABLE ASSISTANCE.

§ 2.1. 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:

1. Parents and their minor children.

2. A parent and minor children.

3. A married couple with no children.

4. One individual.

5. An unmarried pregnant woman.

§ 2.2. 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:

1. The standard of assistance at 90% of need times three.

2. The standard of assistance at 90% of need times six.

3. The standard of assistance at 90% of need times nine.

4. The standard of assistance at 90% of need times 12 or the maximum for the locality times 12.

§ 2.3. 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.

§ 2.4. 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:

1. Assistance will not be restricted.

2. Assistance will be restricted.

§ 2.5. 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:

1. The standard of assistance at 90% of need times three.

2. The standard of assistance at 90% of need times six.

3. The standard of assistance at 90% of need times nine.

4. The standard of assistance at 90% of need times 12 or the maximum for the locality times 12.

§ 2.6. 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:

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 12 months out of 12 consecutive months.

§ 2.7. 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 12 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 12 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 12 months out of 12 consecutive months.

§ 2.8. 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 12 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.

§ 2.9. 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 12 months out of 12 consecutive months.

~~§ 2.10 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.~~

DIRECTOR'S ORDER NUMBER THIRTY-FOUR (91)

VIRGINIA'S FOURTEENTH INSTANT GAME LOTTERY; "THE BIG DEAL," END OF GAME.

In accordance with the authority granted by Section 58.1-4006A of the Code of Virginia, I hereby give notice that Virginia's fourteenth instant game lottery, "The Big Deal," will officially end at midnight on Thursday, January 16, 1992. The last day for lottery retailers to return for credit unsold tickets from "The Big Deal" will be Thursday, February 6, 1992. The last day to redeem winning tickets for "The Big Deal" will be Tuesday, July 14, 1992, 180 days from the declared official end of the game. Claims for winning tickets from "The Big Deal" will not be accepted after that date. Claims which are mailed and received in an envelope bearing a postmark of July 14, 1992, will be deemed to have been received on time. This notice amplifies and conforms to the duly adopted State Lottery Board regulations for the conduct of instant game lotteries.

This order is 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: December 24, 1991

DIRECTOR'S ORDER NUMBER ONE (92)

"LOTTO BY MAIL SWEEPSTAKES"; FINAL RULES FOR GAME OPERATION.

In accordance with the authority granted by Section 58.1-4006A of the Code of Virginia, I hereby promulgate the "Lotto By Mail Sweepstakes" game rules for the Virginia Lottery's subscription and commercial television consortium promotional program to be conducted from Monday, January 13, 1992 through Saturday, February 22, 1992. 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 unless amended or rescinded by further Director's Order.

/s/ Kenneth W. Thorson
Director
Date: January 10, 1992

DIRECTOR'S ORDER NUMBER TWO (92)

"SUNKEN TREASURE"; PROMOTIONAL GAME AND DRAWING RULES

In accordance with the authority granted by Section 58.1-4006A of the Code of Virginia, I hereby promulgate the "Sunken Treasure" promotional game and drawing rules for the kickoff events which will be conducted at various lottery retailer locations throughout the Commonwealth on Thursday, February 13, 1992. 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 February 29, 1992, unless otherwise extended by the Director.

/s/ Kenneth W. Thorson
Director
Date: January 15, 1992

DIRECTOR'S ORDER NUMBER THREE (92)

"HIDDEN TREASURE"; VIRGINIA LOTTERY RETAILER SALES PROMOTIONAL PROGRAM RULES.

In accordance with the authority granted by Section 58.1-4006A of the Code of Virginia, I hereby promulgate the "Hidden Treasure" Virginia Lottery Retailer Sales Promotional Program Rules for the lottery retailer incentive program which will be conducted from Monday, February 3, 1992 through Sunday, March 29, 1992. 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: January 14, 1992

DIRECTOR'S ORDER NUMBER FOUR (92)

"LOTTO BY MAIL SWEEPSTAKES"; FINAL RULES FOR GAME OPERATION; REVISED.

In accordance with the authority granted by Section 58.1-4006A of the Code of Virginia, I hereby promulgate the revised "Lotto By Mail Sweepstakes" game rules for the Virginia Lottery's subscription and commercial television consortium promotional program to be conducted from Monday, January 13, 1992 through Saturday, February 22, 1992. 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 supersedes Director's Order Number One (92), issued January 10, 1992. The 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: January 17, 1992

GOVERNOR'S COMMENTS ON PROPOSED REGULATIONS

(Required by § 9-6.12:9.1 of the Code of Virginia)

ALCOHOLIC BEVERAGE CONTROL BOARD

Title of Regulations:
VR 125-01-1. Procedural Rules for the Conduct of Hearings Before the Board and Its Hearing Officers and the Adoption or Amendment of Regulations.
VR 125-01-2. Advertising.
VR 125-01-3. Tied House.
VR 125-01-5. Retail Operations.
VR 125-01-6. Manufacturers and Wholesalers Operations.
VR 125-01-7. Other Provisions.

Governor's Comment:

I have no substantive objection to the proposed changes in regulations and recommend approval.

/s/ Lawrence Douglas Wilder
Governor
Date: January 20, 1992

DEPARTMENT OF CORRECTIONS (STATE BOARD OF)

Title of Regulation: **VR 230-30-006. Work/Study Release Standards for Local Facilities.**

Governor's Comment:

The promulgation of this regulation is intended to establish criteria for administering and supervising work release and study release programs operated by local correctional facilities. I recommend that the State Board of Corrections, prior to its final approval of this regulation, carefully consider and address the comments submitted by the Department of Planning and Budget and any which may be received from the public during the public comment period.

/s/ Lawrence Douglas Wilder
Governor
Date: January 16, 1992

DEPARTMENT FOR THE DEAF AND HARD OF HEARING

Title of Regulation: **VR 245-02-01. Regulations Governing Eligibility Standards and Application Procedures for the Distribution of Telecommunication Equipment.**

Governor's Comment:

I concur with the form and content of this proposal. My final approval will be contingent upon a review of the public's comments.

/s/ Lawrence Douglas Wilder
Governor
Date: January 13, 1992

BOARD OF YOUTH AND FAMILY SERVICES

Title of Regulation: **VR 690-03-01. Standards for Secure Detention Homes.**

Governor's Comment:

Promulgation of these regulations would establish operating standards for the care and custody of youth in secure detention homes by the Department of Youth and Family Services. Approval is recommended.

/s/ Lawrence Douglas Wilder
Governor
Date: January 15, 1992

Symbol Key †
† Indicates entries since last publication of the Virginia Register

GENERAL NOTICES

NOTICE

Notices of Intended Regulatory Action are being published as a separate section of the Register beginning with the October 7, 1991, issue. The new section appears at the beginning of each issue.

DEPARTMENT OF GENERAL SERVICES

Division of Forensic Science

† Notice to the Public

Title of Regulation: **VR 330-02-01. Regulations for Breath Alcohol Testing.**

Statutory Authority: §§ 18.2-267 and 18.2-268 of the Code of Virginia.

In accordance with § 3.2 of the Regulations for Breath Alcohol Testing and under authority of § 18.2-267 of the Code of Virginia, the following devices are approved for use as preliminary breath test devices:

1. ALCOLYSER, manufactured by Lyon Laboratories, Ltd., Cardiff, Wales, United Kingdom.

2. The PREVENT, manufactured by BHP Diagnostix, West Chester, PA.

3. The A.L.E.R.T. (Alcohol Level Evaluation Road Tester), Models J2A, J3A, and J3AC, manufactured by Alcohol Countermeasure Systems, Inc., Port Huron, MI.

4. The ALCO-SENSOR, ALCO-SENSOR II and ALCO-SENSOR III, manufactured by Intoximeters, Inc., St. Louis, MO.

5. The CMI SD 2, manufactured by Lyon, Laboratories, Barry, United Kingdom.

6. The LIFE LOC PBA 3000, manufactured by Life Loc Inc., Wheat Ridge, CO.

In accordance with § 2.7 of the Regulations for Breath Alcohol Testing and under authority of § 18.2-268 of the Code of Virginia, the following ampuls are approved for use in conducting breath tests on approved breath test devices:

1. Breathalyzer ampuls, manufactured by National Draeger, Inc., Pittsburgh, PA.

2. Tru-Test ampuls, manufactured by Systems Innovation Inc., Hallstead, PA.

3. Guth ampuls, manufactured by Guth Laboratories, Inc., Harrisburg, PA.

In accordance with § 2.6 of the Regulations for Breath Alcohol Testing and under authority of § 18.2-268 of the Code of Virginia, the following breath test devices are approved for use in conducting breath tests:

1. The Breathalyzer, Model 900-A, manufactured by Stephenson Corporation, Red Bank, NJ.

2. The Breathalyzer, Model 900-A, manufactured by Smith & Wesson Corp., Springfield, MA.

2. The Breathalyzer, Model 900-A, manufactured by National Draeger, Inc., Pittsburgh, PA.

4. The Intoximeter, Model 3000 equipped with the Virginia field module and external printer, manufactured by Intoximeters, Inc., Richmond, CA.

DEPARTMENT OF LABOR AND INDUSTRY

Notice to the Public

Statement of Final Agency Action

Virginia Occupational Safety and Health Standards for the General Industry

Extension of Partial Stay to Amendment to the General Industry Standard for Occupational Exposure to Asbestos, Tremolite, Anthophyllite and Actinolite, 1910.1001, 1926.58

VR 425-02-10

On November 26, 1991, the Virginia Safety and Health Codes Board adopted an Extension of the Partial Stay to the Amended Standard to the Final Rule of the Virginia Occupational Safety and Health Standards for General Industry entitled, "VR 425-02-10, Occupational Exposure to Asbestos, Tremolite, Anthophyllite and Actinolite, 1910.1001 and 1926.58."

The effective date of the stay is November 27, 1991, and it will remain in effect until February 28, 1992, to allow

OSHA to complete supplemental rulemaking limited to the issue of whether non-asbestiform tremolite, anthophyllite and actinolite should continue to be regulated in the same standard as asbestos, or should be treated in some other way. OSHA also is making minor conforming amendments to notes to the affected standards.

VIRGINIA CODE COMMISSION

NOTICE 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.

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.

ERRATA

DEPARTMENTS OF EDUCATION; MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES; SOCIAL SERVICES; AND YOUTH AND FAMILY SERVICES

Title of Regulation: **VR 270-01-003, VR 470-02-01, VR 615-29-02, and VR 690-40-004. Standards for Interdepartmental Regulation of Residential Facilities for Children.**

Publication: 8:8 VA.R. 1287-1326 January 13, 1992.

Correction to Final Regulation:

Page 1288, the definitions of "Approval" and "Aversive stimuli" were merged and portions of both were deleted. These definitions are revised to read:

"Approval" means the process of recognizing that a public facility or an out-of-state facility has complied with standards for licensure or certification. (In this document the words "license" or "licensure" will include approval of public and out-of-state facilities except when describing enforcement and other negative sanctions which are described separately for these facilities.)

"Aversive stimuli" means physical forces (e.g., sound, electricity, heat, cold, light, water, or noise) or substances (e.g., hot pepper or pepper sauce on the tongue) measurable in duration and intensity which when applied to a client are noxious or painful to the client, but in no case shall the term "aversive stimuli" include striking or hitting the client with any part of the body or with an implement or pinching, pulling, or shaking the client.

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

BOARD OF AGRICULTURE AND CONSUMER SERVICES

† **February 26, 1992 - 1 p.m.** – Open Meeting
† **February 27, 1992 - 9 a.m.** – Open Meeting
Washington Building, Room 204, 1100 Bank Street, Richmond, Virginia. ♿

A regular meeting to discuss legislation, 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. At the conclusion of other business, the board will review public comments for a period not to exceed 30 minutes.

Contact: Roy E. Seward, Secretary to the Board, Virginia Department of Agriculture and Consumer Services, Washington Building, Room 210, 1100 Bank Street, Richmond, VA 23219, telephone (804) 786-3501.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Virginia Apple Board

February 20, 1992 - 10 a.m. – Open Meeting
1219 Stoneburner Street, Staunton, Virginia. (Interpreter for deaf provided upon request)

The board convenes to conduct matters of business affecting the Virginia Apple Industry. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes.

NOTE: CHANGE OF ADDRESS
Contact: Clayton O. Griffin, Director, P.O. Box 718, Staunton, VA 24401, telephone (703) 332-7790.

Virginia Bright Flue-Cured Tobacco Board

† **February 21, 1992 - 10 a.m.** – Open Meeting
Sheldon's Restaurant, Keysville, Virginia. ♿

A meeting to consider funding proposals for research, promotion and education projects pertaining to Virginia flue-cured tobacco and other business that may come before the board. Public comment will be received at approximately 10:30 a.m.

Contact: D. Stanley Duffer, Secretary, P.O. Box 129, Halifax, VA 24558, telephone (804) 572-4568 or SCATS 791-5215.

Virginia Cattle Industry Board

February 13, 1992 - 11:30 a.m. – Open Meeting
The Homestead, Hot Springs, Virginia. ♿

A meeting to review the financial situation, hear mid-year research reports and updates on various ongoing projects. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes.

Contact: Reginald Reynolds, Executive Director, Virginia Cattle Industry Board, P.O. Box 176, Daleville, VA 24083, telephone (703) 992-1009.

Virginia Corn Board

† **February 20, 1992 - 9 a.m.** – Open Meeting
† **February 21, 1992 - 9 a.m.** – Open Meeting
Williamsburg Hilton and Conference Center, 50 Kingsmill Road, Williamsburg, Virginia. ♿

The board will meet in regular session to discuss issues related to Virginia corn industry and to hear project reports and proposals on the first day. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes.

Contact: Rosser Cobb, Program Director, P.O. Box 26, Warsaw, VA 22572, telephone (804) 333-3710.

Virginia Sweet Potato Board

March 11, 1992 - 7:30 p.m. – Open Meeting
Eastern Shore Agriculture Experiment Station, Route 1, Box 133, Research Drive, Painter, Virginia.

A meeting to discuss marketing, promotion, research and education programs for the state's sweet potato industry and to develop the board's annual budget. At the conclusion of other business, the board will entertain public comments for a period not to exceed 30 minutes.

Contact: J. William Mapp, Program Director, Box 26, Onley, VA 23418, telephone (804) 787-5867.

Virginia Winegrowers Advisory Board

† **April 6, 1992 - 10 a.m.** – Open Meeting
Virginia Agricultural Experiment Station, 2500 Valley Avenue, Winchester, Virginia.

The board will (i) hear reports from Committee Chairs and Project Monitors; (ii) review old and new business; and (iii) hear and vote on new proposals for the 1992-1993 fiscal year.

Contact: Annette C. Ringwood, Wine Marketing Specialist, 1100 Bank Street, Suite 1010, Richmond, VA 23219, telephone (804) 371-7685.

ALCOHOLIC BEVERAGE CONTROL BOARD

February 19, 1992 - 9:30 a.m. – Open Meeting
March 2, 1992 - 9:30 a.m. – Open Meeting
March 16, 1992 - 9:30 a.m. – Open Meeting
March 30, 1992 - 9:30 a.m. – Open Meeting
2901 Hermitage Road, Richmond, Virginia.

A meeting to receive and discuss reports and activities from staff members. Other matters not yet determined.

Contact: Robert N. Swinson, Secretary to the Board, 2901 Hermitage Road, P.O. Box 27491, Richmond, VA 23261, telephone (804) 367-0616.

ARCHITECTS, LAND SURVEYORS, PROFESSIONAL ENGINEERS AND LANDSCAPE ARCHITECTS, BOARD FOR

Board for Professional Engineers

February 11, 1992 - 9 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia.

A meeting to (i) approve minutes from November 5, 1991, meeting; (ii) review correspondence; (iii) review enforcement files; and (iv) review applications.

Contact: Willie Fobbs, III, Assistant Director, Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-8514.

ASAP POLICY BOARD - ROCKBRIDGE

Board of Directors

† **February 25, 1992 - 3 p.m.** – Open Meeting
2044 Sycamore Avenue, Buena Vista, Virginia.

A meeting to include call to order, approval of minutes from November 12, 1992, old business, new business, and treasurer's report.

Contact: S. Diane Clark, Director, 2044 Sycamore Avenue, Buena Vista, VA 24416, telephone (703) 261-6281.

BOARD FOR BARBERS

February 10, 1992 - 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 and disposition of enforcement cases; and (iv) conduct routine board business.

Contact: Roberta L. Banning, Assistant Director, 3600 West Broad Street, Richmond, VA 23230-4917, telephone (804) 367-8590.

STATE BUILDING CODE TECHNICAL REVIEW BOARD

† **February 28, 1992 - 10 a.m.** – Open Meeting
Virginia Housing Development Authority, 601 Belvidere Street, Conference Room #2, Richmond, Virginia.
(Interpreter for deaf provided upon request)

A meeting to (i) consider requests for interpretation of the Virginia Uniform Statewide Building Code; (ii) consider appeals from the rulings of local appeal boards regarding application of the Virginia Uniform Statewide Building Code; and (iii) approve minutes of previous meeting.

Contact: Jack A. Proctor, 205 North Fourth Street, Richmond, VA 23219, telephone (804) 371-7772.

CHESAPEAKE BAY LOCAL ASSISTANCE BOARD

February 27, 1992 - 10 a.m. – Open Meeting
Virginia Housing Development Authority, Conference Room #1, 601 South Belvidere Street, Richmond, Virginia.

(Interpreter for deaf provided upon request)

The board will conduct general business, including review of local Chesapeake Bay Preservation Area programs. Public comment will be heard early in the meeting. A tentative agenda will be available from the Chesapeake Bay Local Assistance Department by February 20, 1992.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

March 26, 1992 - 10 a.m. – Open Meeting
State Water Control Board, Conference Room, Innsbrook Corporate Center, 4900 Cox Road, Glen Allen, Virginia. ♿ (Interpreter for deaf provided upon request)

The board will conduct general business, including review of local Chesapeake Bay Preservation Area programs. Public comment will be heard early in the meeting. A tentative agenda will be available from the Chesapeake Bay Local Assistance Department by March 19, 1992.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Central Area Review Committee

February 10, 1992 - 10 a.m. – Open Meeting
Middle Peninsula Planning District Commission, Business 17, Saluda, Virginia. ♿ (Interpreter for deaf provided upon request)

February 24, 1992 - 10 a.m. – Open Meeting
James City County Offices, 101A Mounts Bay Road, Williamsburg, Virginia. ♿ (Interpreter for deaf provided upon request)

March 9, 1992 - 10 a.m. – Open Meeting
March 23, 1992 - 10 a.m. – Open Meeting
General Assembly Building, Senate Room B, 9th and Broad Streets, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area Programs for the Central Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Northern Area Review Committee

February 12, 1992 - 10 a.m. – Open Meeting
February 26, 1992 - 10 a.m. – Open Meeting
March 11, 1992 - 10 a.m. – Open Meeting
March 25, 1992 - 10 a.m. – Open Meeting
Council on the Environment, Conference Room, 9th Street Office Building, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area Programs for the Northern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify meeting time, location and schedule. No comments from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Regulatory Review Committee and Program Study Group

February 19, 1992 - 10 a.m. – Open Meeting
Monroe Building, Meeting Room C, 101 North 14th Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

March 18, 1992 - 10 a.m. – Open Meeting
Monroe Building, Meeting Room E, 101 North 14th Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will consider issues relating to Chesapeake Bay Preservation Area Designation and Management Regulations, VR 173-02-01. No public comment will be taken.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

Southern Area Review Committee

February 19, 1992 - 10 a.m. – Open Meeting
March 4, 1992 - 10 a.m. – Open Meeting
March 18, 1992 - 10 a.m. – Open Meeting
Council on the Environment, Conference Room, 9th Street Office Building, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

The committee will review Chesapeake Bay Preservation Area Programs for the Southern Area. Persons interested in observing should call the Chesapeake Bay Local Assistance Department to verify

meeting time, location and schedule. No comments from the public will be entertained at the Review Committee meetings. However, written comments are welcome.

Contact: Receptionist, Chesapeake Bay Local Assistance Department, 805 E. Broad St., Suite 701, Richmond, VA 23219, telephone (804) 225-3440 or toll-free 1-800-243-7229/TDD ☎

CHILD DAY-CARE COUNCIL

† **February 12, 1992 - 8 a.m.** – Open Meeting
† **February 19, 1992 - 8 a.m.** – Open Meeting
† **February 26, 1992 - 8 a.m.** – Open Meeting
† **March 4, 1992 - 8 a.m.** – Open Meeting
† **March 11, 1992 - 8 a.m.** – Open Meeting
Koger Executive Center, West End, Blair Building, Conference Room, 2nd Floor, 1604 Santa Rosa Road, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to discuss legislation affecting child care centers, camps, school age programs, and preschool/nursery schools.

† **February 13, 1992 - 9 a.m.** – Open Meeting
Koger Executive Center, West End, Blair Building, Conference Rooms A and B, 8007 Discovery Drive, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to discuss issues, concerns and programs that impact child care centers, camps, school age programs, and preschool/nursery schools. The public comment period begins at 1 p.m.

Contact: Peggy Friedenberg, Legislative Analyst, Office of Governmental Affairs, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

INTERDEPARTMENTAL REGULATION OF RESIDENTIAL FACILITIES FOR CHILDREN

Coordinating Committee

† **February 12, 1992 - 8:30 a.m.** – Open Meeting
† **March 20, 1992 - 8:30 a.m.** – Open Meeting
Office of Coordinator, Interdepartmental Regulation, 1603 Santa Rosa Road, Tyler Building, Suite 208, Richmond, Virginia. ♿

A meeting 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, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-7124.

BOARD OF COMMERCE

February 24, 1992 - 10 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

A regular quarterly meeting. Agenda will likely consist of briefings from staff on the status of bills in the General Assembly that can have an impact upon agency operations, and agency regulatory programs.

Contact: Alvin D. Whitley, Secretary/Policy Analyst, Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-8564.

COMPENSATION BOARD

February 27, 1992 - 5 p.m. – Open Meeting
March 26, 1992 - 5 p.m. – Open Meeting
Ninth Street Office Building, Room 913/913A, 9th Floor, 202 North Ninth Street, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

A routine meeting to conduct business.

Contact: Bruce W. Haynes, Executive Secretary, P.O. Box 3-F, Richmond, VA 23206-0686, telephone (804) 786-3886.

DEPARTMENT OF CONSERVATION AND RECREATION

Falls of the James Scenic River Advisory Board

February 21, 1992 - Noon – Open Meeting
Planning Commission Conference Room, Fifth Floor, City Hall, Richmond, Virginia.

A meeting to review river issues and programs.

Contact: Richard G. Gibbons, Environmental Program Manager, Department of Conservation and Recreation, 203 Governor St., Suite 326, Richmond, VA 23219, telephone (804) 786-4132 or (804) 786-2121/TDD ☎

Upper James Scenic River Advisory Board

February 12, 1992 - Noon – Open Meeting
Sunnybrook Inn, Hollins, Virginia.

A meeting to review river issues and programs.

Contact: Richard G. Gibbons, Environmental Program 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 (804) 786-2121/TDD ☎

BOARD FOR CONTRACTORS

† **February 19, 1992 - 6 p.m.** – Public Hearing
Municipal Building, Council Chambers, Room 450, Roanoke, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board for Contractors intends to amend regulations entitled: **VR 220-01-2. Board for Contractors Licensing Regulations.** These amendments are proposed to enhance the administration of the board's regulations, thereby promoting public health, safety and welfare, as well as benefiting consumers and licensed/registered contractors.

STATEMENT

Basis, Purpose, Substance, Issues and Impact: Pursuant to Virginia Code § 54.1-1102 and in accordance with Chapter 1.1:1 (§ 9-6.14:1 et seq.) of Title 9 of the Code of Virginia, the Board for Contractors proposes to amend, add to, delete and reorganize its existing regulations governing licensed and registered contractors.

The regulations apply to firms and individuals performing construction, removal, repair or improvements when the total value referred to in a single contract is $1,500 or more or when the work is for the purpose of constructing a water well to reach ground water as defined in § 62.1-44.85 (8) regardless of contract or project amount, or when the total value of all such construction is $300,000 or more in any twelve-month period.

These proposed regulations have been amended to define the specialty services which contractors may perform under the "specialty contractors" license classification, eliminate the $15,000 net worth entry requirement for Class B contractors, provide a section on the filing of charges under standards of conduct and include two new prohibited acts. In addition, theses proposed changes provide regulatory revisions and amended language for the purpose of clarification, as well as a reduction in the fees that can be required for trade-related examinations offered by the Board for Contractors.

These regulations apply directly to approximately 18,519 licensed Class A contractors and 22,795 licensed/registered Class B contractors.

Statutory Authority: § 54.1-1102 of the Code of Virginia.

Written comments may be submitted until April 10, 1992.

Contact: Florence R. Brassier, Assistant Director, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-8557.

Complaints Committee

† **February 27, 1992 - 9 a.m.** – Open Meeting
3600 West Broad Street, 5th Floor, Conference Room 1, Richmond, Virginia.

A meeting to review and consider complaints filed by consumers against licensed contractors and to review reports from Informal Fact-Finding conferences.

Contact: A.R. Wade, Assistant Director, Investigation and Adjudication, 3600 West Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 367-8585.

BOARD OF CORRECTIONS

February 12, 1992 - 10 a.m. – Open Meeting
† **March 11, 1992 - 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 to the board.

Contact: Mrs. Vivian Toler, Secretary to the Board, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3235.

Liaison Committee

February 13, 1992 - 10 a.m. – Open Meeting
† **March 12, 1992 - 9:30 a.m.** – Open Meeting
6900 Atmore Drive, Board of Corrections Board Room, Richmond, Virginia.

A meeting to address and discuss criminal justice issues.

Contact: Mrs. Vivian Toler, Secretary to the Board, 6900 Atmore Drive, Richmond, VA 23225, telephone (804) 674-3235.

DEPARTMENT OF CORRECTIONS (STATE BOARD OF)

NOTE: CHANGE IN PUBLIC HEARING DATE
February 12, 1992 - 10 a.m. – Public Hearing
6900 Atmore Drive, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Board of Corrections intends to amend regulations entitled: **VR 230-30-006. Work/Study Release Standards for Local Facilities.** The proposed regulations establish the minimum operational standards for work or study release programs in local correctional facilities.

Statutory Authority: §§ 53.1-5 and 53.1-131 of the Code of Virginia.

Written comments may be submitted until January 3, 1992.

Contact: Mike Howerton, Chief of Operations, 6900 Atmore

Drive, Richmond, VA 23225, telephone (804) 674-3041.

DEPARTMENT OF CRIMINAL JUSTICE SERVICES (BOARD OF)

March 6, 1992 - 1 p.m. – Public Hearing
Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Board of Criminal Justice Services intends to adopt regulations entitled: **VR 240-04-3. Rules Relating to the Court-Appointed Special Advocate Program (CASA).** The purpose of the proposed regulation is to regulate the operation of local Court-Appointed Special Advocate programs.

Statutory Authority: §§ 9-173.7 and 9-173.8 of the Code of Virginia.

Written comments may be submitted until February 3, 1992, to Francine Ecker, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219.

Contact: Paula J. Scott, Executive Assistant, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-8730.

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April 1, 1992 - 9 a.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 Criminal Justice Services Board intends to amend regulations entitled: **VR 240-01-2. Rules Relating to Compulsory In-Service Training Standards for Law-Enforcement Officers, Jailors or Custodial Officers, Courtroom Security Officers, Process Service Officers and Officers of the Department of Corrections Institutional Services.** The proposed amendments mandate in-service training requirements for those criminal justice officers specified in the title of the regulation.

Statutory Authority: § 9-170 of the Code of Virginia.

Written comments may be submitted until March 12, 1992.

Contact: L.T. Eckenrode, Division Director, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-4000.

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April 1, 1992 - 9 a.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 Criminal Justice Services Board intends to amend regulations entitled: **VR 240-01-12. Rules Relating to Certification of Criminal Justice Instructors.** These proposed amendments set forth mandated training requirements for certification of Criminal Justice Instructors.

Statutory Authority: § 9-170 of the Code of Virginia.

Written comments may be submitted until March 12, 1992.

Contact: L.T. Eckenrode, Division Director, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-8475.

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April 1, 1992 - 2:30 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 Criminal Justice Services Board intends to adopt regulations entitled: **VR 240-04-2. Rules Relating to the Forfeited Drug Asset Sharing Program.** The purpose of the proposed regulation is to regulate the administration of the Forfeited Drug Asset Sharing Program.

Statutory Authority: §§ 19.2-386.4, 19.2-386.10 and 19.2-386.14 of the Code of Virginia.

Written comments may be submitted until February 28, 1992.

Contact: Paula J. Scott, Executive Assistant, Department of Criminal Justice Services, 805 East Broad Street, Richmond, Virginia 23219, telephone (804) 786-8730.

DEPARTMENT FOR THE DEAF AND HARD OF HEARING

February 28, 1992 – 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 for the Deaf and Hard of Hearing intends to amend regulations entitled: **VR 245-03-01. Regulations Governing Interpreter Services for the Deaf and Hard of Hearing.** These regulations are used to establish guidelines for assessing transliterating or interpreting skills of individuals who wish to achieve a VQAS screening level.

Statutory Authority: § 63.1-85.4 of the Code of Virginia.

Written comments may be submitted until February 28, 1992.

Contact: Kathy E. Vesley, Deputy Director, Department for the Deaf and Hard of Hearing, Washington Building, Capitol Square, 1100 Bank Street, 12th Floor, Richmond, Virginia 23219, telephone (804) 225-2570/Voice/TDD ☎ or toll-free 1-800-552-7917/Voice/TDD ☎

VIRGINIA EDUCATION LOAN AUTHORITY

Board of Directors

† **February 24, 1992 - 10 a.m.** – Open Meeting
737 North 5th Street, Third Floor Boardroom, Richmond, Virginia. ♿

A general business meeting.

Contact: Catherine E. Fields, Administrative Assistant, One Franklin Square, 411 East Franklin Street, Suite 300, Richmond, VA 23219, telephone (804) 775-4648, toll-free 1-800-792-LOAN or SCATS (804) 786-2035.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

February 11, 1992 - 9 a.m. – Open Meeting
Monroe Building, Council Conference Room, 9th Floor, Richmond, Virginia. ♿

A general business meeting. For more information contact the Council.

Contact: Anne Pratt, Associate Director, 101 North Fourteenth Street, 9th Floor, Richmond, VA 23219, telephone (804) 225-2629.

LOCAL EMERGENCY PLANNING COMMITTEE - CHESTERFIELD COUNTY

April 2, 1992 - 5:30 p.m. – Open Meeting
Chesterfield County Administration Building, 10001 Ironbridge Road, Chesterfield, Virginia. ♿

A meeting to meet requirements of Superfund Amendment and Reauthorization Act of 1986.

Contact: Linda G. Furr, Assistant Emergency Services, Chesterfield Fire Department, P.O. Box 40, Chesterfield, VA 23832, telephone (804) 748-1236.

LOCAL EMERGENCY PLANNING COMMITTEE - CITIES OF HAMPTON, NEWPORT NEWS, WILLIAMSBURG AND POQUOSON AND THE COUNTY OF YORK

February 11, 1992 - 9 a.m. – Public Hearing
Hampton Central Library (formerly Charles Taylor Library), Room A, 4207 Victoria Boulevard, Hampton, Virginia. ♿

A public hearing to receive comments from the public on the Peninsula Local Emergency Response Plan. The plan was prepared to satisfy the requirements of Section 303(c) of Title III of the Superfund Amendments and Reauthorization Act of 1986 and describes the methods and procedures to be followed in the event of a release or spill of extremely hazardous substances.

Copies of the plan are available for review in the offices of the Hampton Roads Planning District Commission at Harbour Centre, Suite 502, 2 Eaton Street, Hampton, Virginia 23669 during normal business hours.

Contact: Henry M. Cochran, Deputy Executive Director, 2 Eaton Street, Suite 502, Hampton, VA 23669, telephone (804) 782-2067.

LOCAL EMERGENCY PLANNING COMMITTEE - CITY OF PORTSMOUTH

March 11, 1992 - 9 a.m. – Open Meeting
St. Julian's Annex, Building 307, Victory Boulevard at Magazine Road, Portsmouth, Virginia.

A general meeting.

Contact: Karen Karpowski, Portsmouth Fire Department, 361 Effingham Street, Portsmouth, VA 23704-2337, telephone (804) 393-8765.

VIRGINIA FIRE SERVICES BOARD

† **February 20, 1992 - 7:30 p.m.** – Open Meeting
† **February 21, 1992 - 9 a.m.** – Open Meeting
Holiday Inn I-64, 6531 West Broad Street, Richmond, Virginia.

A regular meeting to discuss training and fire policies. The meeting is open to the public for their comments and input. This meeting will convene in approximately 2 hours and will re-convene at 9 a.m. on Friday, February 21, 1992.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

Fire Prevention and Control Committee

† **February 20, 1992 - 9 a.m.** – Open Meeting
Holiday Inn I-64, 6531 West Broad Street, Richmond, Virginia.

A meeting to discuss fire training and policies. The committee meeting is open to the public for their comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

Fire Training/EMS Education Committee

† **February 20, 1992 - 1 p.m.** – Open Meeting
Holiday Inn I-64, 6531 West Broad Street, Richmond, Virginia.

A meeting to discuss fire training and policies. The committee meeting is open to the public for their comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

Legislative/Liaison Committee

† **February 20, 1992 - 1 p.m.** – Open Meeting
Holiday Inn I-64, 6531 West Broad Street, Richmond, Virginia.

A meeting to discuss fire training and policies. The committee meeting is open to the public for their comments and input.

Contact: Ann J. Bales, Executive Secretary Senior, 2807 Parham Road, Suite 200, Richmond, VA 23294, telephone (804) 527-4236.

BOARD OF GAME AND INLAND FISHERIES

† **March 6, 1992 - 9:30 a.m.** – Open Meeting
4010 West Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

Committees of the Board of Game and Inland Fisheries will meet to review those agenda items appropriate to its authority, beginning with the Wildlife and Boat Committee, followed by the Liaison, Finance, Planning and Law and Education Committees. In addition to the nongame regulation proposals that were carried over from the October 1991 meeting, the Wildlife and Boat Committee will also consider a proposed bear hound training season west of the Blue Ridge Mountains and receive information on fishing in the proximity of occupied waterfowl blinds.

† **March 7, 1992 - 9 a.m.** – Open Meeting
4010 West Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

The board will meet to adopt for advertisement the nongame regulation proposals, and the proposed bear hound training season as well as extending the raccoon hound training season west of the Blue Ridge Mountains. These proposals will be brought back to the board for adoption as final regulations at the May 14, 15 and 16, 1992, meeting to be held in Farmville, Virginia. Committee reports will be given and other general and administrative matters, as necessary, will be discussed.

Contact: Belle Harding, Secretary to Bud Bristow, 4010 W. Broad Street, P.O. Box 11104, Richmond, VA 23230, telephone (804) 367-1000.

BOARD FOR GEOLOGY

February 13, 1992 - 10 a.m. – Open Meeting
February 14, 1992 - 10 a.m. – Open Meeting
Department of Commerce, 3600 West Broad Street, Conference Room 2, Richmond, Virginia. ♿

A general board meeting.

Contact: Nelle P. Hotchkiss, Assistant Director, 3600 West Broad Street, Richmond, VA 23230, telephone (804) 367-8595.

DEPARTMENT OF GENERAL SERVICES

Forensic Science Advisory Board

† **February 14, 1992 - 10 a.m.** – Open Meeting
Monroe Tower Building, Conference Room C, 101 North 14th Street, Richmond, Virginia.

A meeting to discuss issues, concerns and programs that impact the division and its user agencies.

Contact: Paul B. Ferrara, Division Director, Division of Forensic Science, 1 North 14th Street, Richmond, VA 23219, telephone (804) 786-2281.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

DEPARTMENT OF HEALTH

Division of Shellfish Sanitation

† **March 16, 1992 - 7 p.m.** – Open Meeting
Eastern Shore Community College, Melfa, Virginia. ♿

A meeting to (i) discuss the shellfish sanitation program in Virginia; (ii) discuss the closure of Parker Creek, a tributary of Metompkin Bay in Accomack County; and (iii) discuss other related topics if requested.

Contact: Mary Wright, Classification Chief, 1500 East Main Street, Room 109-31, Richmond, VA 23219, telephone (804) 786-7937.

DEPARTMENT OF HEALTH (STATE BOARD OF)

February 10, 1992 - 9 a.m. – Public Hearing
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 amend regulations entitled: **VR 355-30-000-06. Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.** The proposed regulations amend the existing Virginia Medical Care Facilities Certificate of Public Need (COPN) Rules and Regulations in order to implement the COPN Program to be consistent with the amended COPN law which became effective July 1, 1991.

Statutory Authority: §§ 32.1-12 and 32.1-102.1 of the Code of Virginia.

Written comments may be submitted until February 28, 1992.

Contact: Paul E. Parker, Director, Division of Resources Development, Virginia Department of Health, P.O. Box 2448, Richmond, VA 23218, telephone (804) 786-7463.

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February 19, 1992 - 10 a.m. – Public Hearing
Main Floor Conference Room, James Madison Building, 109 Governor 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 amend regulations entitled: **VR 355-28-300. Rules and Regulations of the Board of Health, Commonwealth of Virginia, for the Immunization of School Children.** The proposed amendments will make the regulations consistent with the current recommendations of the U.S. Public Health Service.

Statutory Authority: §§ 22.1-271.1, 22.1-272.1, 32.1-46 and 32.1-12 of the Code of Virginia.

Written comments may be submitted until March 16, 1992, to A. Martin Cader, M.D., Virginia Department of Health, Division of Communicable Disease Control, P.O. Box 2448, Room 113, Richmond, VA 23218.

Contact: Marie Krauss, Executive Secretary, Virginia Department of Health, Division of Communicable Disease Control, P.O. Box 2448, Room 113, Richmond, VA 23218, telephone (804) 786-6261.

VIRGINIA HEALTH SERVICES COST REVIEW COUNCIL

February 25, 1992 - 9:30 a.m. – Open Meeting
Blue Cross/Blue Shield of Virginia, 2015 Staples Mill Road, Richmond, Virginia.

The council will conduct its monthly meeting.

Contact: Kim Schulte Barnes, Information Officer, 805 East Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371/TDD

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March 15, 1992 – 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 Health Services Cost Review Council intends to amend regulations entitled: **VR 370-01-001. Rules and Regulations of the Virginia Health Services Cost Review Council.** The proposed amendments (i) waive the audit requirement and the imposition of a penalty if an "extenuating circumstance," such as a bankruptcy proceeding, exists; (ii) require the filing of an institution's historical and its certified audited financial statement prior to acceptance by council of the filing of a subsequent year's budget or the filing of any request for an interim rate increase; and (iii) require each individual licensed health care institution to submit filings, but that the screening process would still be applied to allow for hospital systems to be analyzed systemwide by the Virginia Hospital Rate Review Program.

Statutory Authority: §§ 9-158, 9-159 and 9-164 of the Code of Virginia.

Written comments may be submitted until March 15, 1992.

Contact: G. Edward Dalton, Deputy Director, 805 E. Broad St., 6th Floor, Richmond, VA 23219, telephone (804) 786-6371/TDD

BOARD OF HISTORIC RESOURCES

February 19, 1992 - 10 a.m. – Open Meeting
Old City Hall, Council Chambers, Fredericksburg, Virginia.(Interpreter for deaf provided if requested)

A general business meeting.

Contact: Margaret Peters, Information Director, 221 Governor Street, Richmond, VA 23219, telephone (804) 786-3143 or (804) 786-1934/TDD

DEPARTMENT OF HISTORIC RESOURCES

State Review Board

February 18, 1992 - 10 a.m. – Open Meeting
Virginia Housing Development Authority Building, 601 South Belvidere Street, Richmond, Virginia. ♿ (Interpreter for 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.

Buckroe Beach Carousel, City of Hampton
Center Theater, Norfolk
Crockett's Cove Presbyterian Church, Wythe County
Fairfax Elementary School Annex, City of Fairfax
Godwin House, Chuckatuck, Suffolk
Hughlett's Tavern, Heathsville, Northumberland County
Rothsay, Bedford County
Tastee 29 Diner, City of Fairfax
Norge Historic District, James City County
Onancock Historic District, Accomack County
Rosemont Historic District, Alexandria
Town of Potomac Historic District, Alexandria
Mauplin-Maury House, City of Richmond, (de-listing)

Contact: Margaret Peters, Information Director, 221 Governor Street, Richmond, VA 23219, telephone (804) 786-3143 or (804) 786-1934/TDD ☎

VIRGINIA HISTORIC PRESERVATION FOUNDATION

March 11, 1992 - 9:30 a.m. – Open Meeting
State Treasurer's Office, Board Room, 3rd Floor, Monroe Building, 101 North 14th Street, Richmond, Virginia. ♿ (Interpreter for deaf provided if requested)

A general business meeting.

Contact: Hugh Miller, Director or Margaret Peters, Information Director, 221 Governor Street, Richmond, VA 23219, telephone (804) 786-3143 or (804) 786-1934/TDD ☎

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

Amusement Device Technical Advisory Committee

† **March 5, 1992 - 9 a.m.** – Open Meeting
Seventh Floor Conference Room, 205 North Fourth Street, Richmond, Virginia. ♿

A meeting to review and discuss regulations pertaining to the construction, maintenance, operation and inspection of amusement devices adopted by the Board of Housing and Community Development.

Contact: Jack A. Proctor, CPCA, Deputy Director, Building Regulation, Department of Housing and Community Development, 205 North Fourth Street, Richmond, VA 23219, telephone (804) 786-4752 or (804) 786-5405/TDD ☎

VIRGINIA HOUSING DEVELOPMENT AUTHORITY

† **February 18, 1992 - 11 a.m.** – Open Meeting
601 South Belvidere Street, Richmond, Virginia. ♿

A regular meeting of the Board of Commissioners to (i) review, and if appropriate, approve the minutes from the prior monthly meeting; (ii) consider for approval and ratification mortgage loan commitments under its various programs; (iii) review the authority's operations for the prior month; and (iv) consider such other matters and take such other actions as it may deem appropriate. Various committees of the Board of Commissioners may also meet before or after the regular meeting and consider matters within their purview. The planned agenda of the meeting will be available one week prior to the date of the meeting.

Contact: J. Judson McKellar, Jr., General Counsel, Virginia Housing Development Authority, 601 S. Belvidere Street, Richmond, VA 23220, telephone (804) 782-1986.

DEPARTMENT OF LABOR AND INDUSTRY

Apprenticeship Council

February 20, 1992 - 10 a.m. – Open Meeting
Virginia Housing Development Authority, 601 South Belvidere Street, Conference Room #1, Richmond, Virginia. ♿

A regular meeting to discuss and act on (i) proposed revision to the Deregistration Procedure; (ii) report of task force on part time apprenticeship; (iii) report on Juan Steward's apprenticeship; (iv) report on Project Achieve; (v) community college student apprenticeship program; and (vi) apprenticeship honors certificates.

Contact: Robert S. Baumgardner, Director, Apprenticeship Division, Department of Labor and Industry, 13 South 13th St., Richmond, VA 23219, telephone (804) 786-2381.

Safety and Health Codes Board

† **February 25, 1992 - 10 a.m.** – Open Meeting
The Virginia Housing Center, Conference Room #2, 601 South Belvidere Street, Richmond, Virginia. ♿

The agenda of the board will include Occupational Exposure to Bloodborne Pathogens; Final Rule; 1910.1030.

Contact: John J. Crisanti, Director, Enforcement Policy Office, Department of Labor and Industry, 13 South 13th St., Richmond, VA 23219, telephone (804) 786-2384.

LIBRARY BOARD

March 17, 1992 - 9:30 a.m. – Open Meeting
Virginia State Library and Archives, 3rd Floor, Supreme Court Room, 11th Street at Capitol Square, Richmond, Virginia. ♿

A meeting to discuss administrative matters.

Contact: Jean H. Taylor, Secretary to State Librarian, Virginia State Library and Archives, 11th Street at Capitol Square, Richmond, VA 23219, telephone (804) 786-2332.

STATE COUNCIL ON LOCAL DEBT

† **February 19, 1992 - 11 a.m.** – Open Meeting
† **March 18, 1992 - 11 a.m.** – Open Meeting
101 North 14th Street, James Monroe Building, 3rd Floor, Treasury Board Conference Room, Richmond, Virginia. ♿

A regular meeting; subject to cancellation unless there are action items requiring the Council's consideration. Persons interested in attending should call one week prior to meeting date to ascertain whether or not the meeting is to be held as scheduled.

Contact: Art Bowen, Senior Debt Analyst, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-4929.

LONG-TERM CARE COUNCIL

February 14, 1992 - 9 a.m. – Open Meeting
Virginia Housing Development Authority, 601 South Belvidere Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A general business meeting.

Contact: Janet Lynch, Director, Long-Term Care Council, 700 East Franklin Street, 10th Floor, Richmond, VA 23219, telephone (804) 225-2271.

STATE LOTTERY BOARD

February 24, 1992 - 10 a.m. – Open Meeting
State Lottery Department, 2201 West Broad Street, Richmond, Virginia. ♿

A regular monthly meeting. Business will be conducted according to items listed on the agenda which has not yet been determined. Two periods for public comment are scheduled.

Contact: Barbara L. Robertson, Lottery Staff Officer, State Lottery Department, 2210 W. Broad Street, Richmond, VA 23901, telephone (804) 367-9433.

MARINE RESOURCES COMMISSION

February 25, 1992 - 9:30 a.m. – Open Meeting
2600 Washington Avenue, 4th Floor, Room 403, Newport News, Virginia. ♿ (Interpreter for deaf provided upon request)

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, fishery conservation issues, licensing, shellfish leasing.

Meetings are open to the public. Testimony is taken under oath from parties addressing agenda items on permits and 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 or (804) 247-2292/TDD ☎

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (BOARD OF)

March 27, 1992 – 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 Specialized Care Services: VR 460-02-3.1300. Standards Established and Methods Used to Assure High Quality Care; VR 460-02-4.1940. Methods and Standards for Establishing Payment Rates - Long-Term Care; and VR 460-03-4.1944. Class Resource Cost Assignment, Computation of Service Intensity Index and Ceiling and Rate Adjustments to the Prospective Direct Patient Care Operating Cost Rate - Allowance for Inflation Methodology Base "Current" Operating Rate (Appendix IV to Nursing Home Payment System).** This proposal establishes existing agency policies for providing services to eligible recipients who require intensive nursing and other medical services.

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

Written comments may be submitted until 4:30 p.m., March 27, 1992, to Mary Chiles, Manager, Division of

Quality Care Assurance, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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† **April 10, 1992** – 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 Inpatient Hospital Settlement Agreement: VR 460-02-4.1910. Methods and Standards for Establishing Payment Rates–Inpatient Hospital Care.** This regulation proposes to incorporate into the plan the provisions of the lawsuit final settlement agreement between the Commonwealth and the Virginia Hospital Association.

STATEMENT

Basis and Authority: Section 32.1-324 of the Code of Virginia authorizes Director of the Department of Medical Assistance Services to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Administrative Process Act (APA), in § 9-6.14:9 of the Code, provides for this agency's promulgation of proposed regulations subject to the Department of Planning and Budget's and Governor's reviews.

Section 1902(a)(13)(A) of the Social Security Act is implemented by Title 42 of the Code of Federal Regulations Part 447 Subpart C. This section "requires that the State Plan provide for payment for hospital and long-term care facility services through the use of rates that the state finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations and quality and safety standards and assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to ..[care].. of adequate quality."

The agreement between the Virginia Hospital association (VHS) and the Commonwealth in full and final settlement of the issues raised in Virginia Hospital Association v. Wilder, et al. was executed on December 21, 1990, by Laurens Sartoris for the VHA and by Howard M. Cullum, Secretary of Health and Human Resources for the Commonwealth.

Purpose: This regulation will implement the requirements of the Final Settlement Agreement between the Commonwealth and the VHA.

Summary and Analysis: This regulation amends the methods and standards for establishing payment rates, effective July 1, 1992, for inpatient hospital care services (Attachment 4.19A) by establishing a Payment Adjustment Fund and by adding an additional two percentage points (200 basis points) to DMAS' prescribed inflation allowance used to calculate the prospective operating cost rate and prospective operating cost ceiling for hospitals subject to the prospective payment system of reimbursement (PPS).

In July 1982, DMAS implemented the PPS for hospitals. In March 1986, the VHA, on behalf of its member hospitals, filed suit against DMAS, challenging the Department's methodology for establishing rates for inpatient hospital services as required by the Medicaid Act (Section 1902(a) of the Social Security Act). The VHA alleged that Medicaid payments were inadequate and estimated that its member hospitals would suffer losses of $51.3 million in FY 90 as a result. The Commonwealth denied the VHA allegations and vigorously asserted its compliance with the Medicaid Act.

In December 1990, after five years of litigation, the Commonwealth and VHA agreed to an out-of-court settlement, which left DMAS' inpatient hospital reimbursement methodology intact. The agreement further provided for a Payment Adjustment Fund (PAF) in each of the Commonwealth's fiscal years during the period July 1, 1992, to June 30, 1996. The PAF is to consist of the Commonwealth's cumulative addition of five million dollars in general funds along with corresponding federal financial participation for reimbursement to nonstate owned hospitals in each of the Commonwealth's fiscal years during the period.

Additionally, the agreement provided, effective July 1, 1992, for the prescribed allowance for inflation (the HCFA-type Hospital Basket, adjusted for Virginia, as developed by Data Resources, Inc. (DRI-V)), to be converted to an escalation factor by adding two percentage points (200 basis points) to the then current DRI-V.

Impact: The general funds for this amendment will be requested for the 1992-1994 and 1994-1996 biennial budgets consistent with the terms of the final settlement. The fiscal impact upon general fund dollars is estimated to be as follows:

Payment Adjustment Fund

The PAF will increase expenditures to nonstate owned hospitals as follows:

	FY 93	FY 94
GF	$5.0 M	$10.0 M
NGF	5.0 M	10.0 M
Total	$10.0 M	$20.0 M

Reimbursement Escalator

A change in the reimbursement escalator fro DRI-V to DRI-V plus two percentage points will increase estimated expenditures to all hospitals as follows:

	FY 93	FY 94
GF	$0.85 M	$4.05 M
NGF	0.85 M	4.05 M
Total	$1.70 M	$8.20 M

The impact at MCV/UVA is as follows:

	FY 93	FY 94
GF	$.3 M	$.9 M
NGF	.3 M	1.0 M
Total	$.6 M	$1.9 M

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

Written comments may be submitted until 4:30 p.m., April 10, 1992, to Wm. R. Blakely, Director, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

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† **April 10, 1992** – 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 Provider Disputes and Date of Acquisition. VR 460-03-4.1912. Dispute Resolution for State-Operated Providers; VR 460-02-4.1920. Methods and Standards for Establishing Payment Rates–Other Types of Care; VR 460-03-4.1940:1. Nursing Home Payment System (PIRS).** These amendments establish an appeal mechanism for state-owned facilities which are Medicaid providers and also define a nursing facility's date of acquisition when it is sold.

STATEMENT

Basis and Authority: Section 32.1-324 of the Code of Virginia authorizes the Director of the Department of Medical Assistance Services (DMAS) to administer and amend the Plan for Medical Assistance in lieu of Board action pursuant to the Board's requirements. The Administrative Process Act (APA), in § 9-6.14:9 of the Code, provides for DMAS's promulgation of proposed regulations subject to the Department of Planning and Budget's and Governor's reviews.

Purpose: The purpose of this proposal is to (i) adopt a separate procedure for a state-operated provider to contest action taken by DMAS, and (ii) define the "date of acquisition" for revaluation of assets after a change of ownership of a nursing facility.

Summary and Analysis: The sections of the State Plan for Medical Assistance affected by this proposed regulatory action are: Attachment 4.19 A (new Supplement 2 is being added), Attachment 4.19 B, and Attachment 4.19 D, the Supplement (containing the PIRS nursing home payment methodology).

Dispute Resolution for State-operated Providers: A few state-operated facilities participate in the Medicaid program as contract providers. (Examples include hospitals, home health care agencies, hospital-based nursing facilities, institutions run by the Department of Mental Health, Mental Retardation and Substance Abuse Services, local health department clinics, pharmacies and outpatient dental laboratories, as well as other providers from time to time.) Because a state-operated facility or institution cannot sue or litigate against another agency or arm of the Commonwealth, existing appeal procedures under the Administrative Process Act (which contemplate court review of an agency action) are not appropriate. Therefore, a separate procedure is being established to permit state-operated providers to resolve disagreements.

Date of Acquisition for Nursing Facilities: Federal law provides that, for reimbursement purposes, valuation of capital assets upon a change of ownership of a nursing facility cannot be increased by more than the lesser of two prescribed inflation indices as measured from the "date of acquisition by the seller" to the date of the change of ownership. The Patient Intensity Rating System nursing home payment system (PIRS) has never defined "date of acquisition." Representatives of the Health Care Financing Administration have defined "the date of acquisition" as the date when legal title passes. As a result of previous discussions between DMAS and providers, DMAS concludes that this term should be defined in PIRS and should also address situations where a nursing facility is constructed by an organization related to the provider (with no formal closing process and no date certain regarding legal title to the physical plant).

Impact: The issues are herein discussed in the order established above.

Dispute Resolution for State-operated Providers: The proposed amendment will affect all state-operated providers. However, there is no estimated budgetary impact on DMAS because both state-operated and nonstate-operated providers are subject to the same Medicaid rules and regulations.

Date of Acquisition for Nursing Facilities: Defining "date of acquisition" is not expected to have any budgetary impact. Legal titling does not represent any change in position. Looking to the issue date of a certificate of

occupancy will affect those providers with a related party construction entity. Currently no providers are known to be engaged in any transactions which would be adversely affected by this definition. On the other hand, failure by DMAS to clarify this definition could place the Commonwealth at risk of significantly increased cost reimbursements following the sale of a nursing facility.

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

Written comments may be submitted until 4:30 p.m., April 10, 1992, to Wm. R. Blakely, Director, Division of Cost Settlement and Audit, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23229, telephone (804) 786-7933.

BOARD OF MEDICINE

March 31, 1992 – 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 Medicine intends to amend regulations entitled: **VR 465-09-01. Certification for Optometrists to Prescribe for and Treat Certain Diseases or Abnormal Conditions of the Human Eye and its Adnexa with Certain Therapeutic Pharmaceutical Agents.** The proposed amendments (i) delete the CPR requirements; (ii) redefine the examination format; (iii) redefine the diseases and conditions of the human eye and its adnexa; (iv) add new therapeutic agents; and (v) add a method to treat emergencies.

Statutory Authority: §§ 54.1-2400, 54.1-2957.1, 54.1-2957.2 and 54.1-2957.3 of the Code of Virginia.

Written comments may be submitted until March 31, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Dr., Richmond, VA 23229.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229, telephone (804) 662-9925.

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† **April 13, 1992** – 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 Medicine intends to amend regulations entitled: **VR 465-05-01. Regulations Governing the Practice of Physician's Assistants.** The proposed amendment (i) establishes procedures for maintaining records of approved invasive procedures performed by the assistant; (ii) provides reports to the board upon request of the number of procedures performed and complications resulting from such procedures; (iii) establishes unprofessional conduct for failure to maintain such records; (iv) establishes that the scope of practice shall be the specialty of the supervising physician; and (v) establishes that any acute or significant finding or change of a patient's clinical status by an assistant must be reported to the supervising physician within one hour of findings.

STATEMENT

Basis: Section 54.1-2400 of the Code of Virginia.

Purpose: The proposed amendments to the current regulations, VR 465-05-01, address the need to establish, by protocol, appropriate requirements for the supervising physician to maintain records of all approved invasive procedures performed by the physician's assistant; the reporting to the board, upon request, of such procedures including complications resulting from such procedures performed by the physician's assistant; to establish unprofessional conduct for failure to maintain records and provide reports to the board when requested; to establish scope of practice shall be the specialty of the supervising physician; and to establish the requirement for reporting to the supervising physician, within one hour, any acute or significant findings or changes of a patient's clinical status by the physician's assistant.

Estimated entities and impact: Regulated entities: There are 184 physician's assistants licensed to practice in Virginia under the supervision of a licensed doctor of medicine.

Projected costs to the agency for implementation and enforcement: The Board of Medicine does not project a cost for implementation of the amendments, but does project a minimal expenditure of $10,000 to enforce the amendments. It is projected that 5 to 10 supervising physicians may be found in violation for failure to maintain and report invasive procedures performed by the physician's assistant, filing separate protocols to accommodate different medical specialties providing supervision of the physician's assistant, and ensuring communication between the physician's assistant and physician in clinical setting.

Source of funds: All funds of the Board of Medicine are derived from fees paid by licensees and applicants for licensure.

Explanation of need: The proposed amendments are needed to establish requirements for maintaining records and reporting of invasive procedures performed by the physician's assistants; establish scope of practice requirements for multi-specialties in medicine who employ physician's assistants; and to more clearly define the

one-hour reporting by the physician's assistant to the supervising physician when a change occurs in the patient's clinical status. These amendments will ensure a more adequate means of evaluating the competency of the physician's assistant and utilization by delegation by the supervising physician in the management and delivery of health care to assure the safety and welfare of the public in Virginia.

Impact on small business: If the practice of a physician's assistant is defined as a small business, then the proposed regulations will impact small businesses as described within this statement. The proposed regulations, however, do not differentially impact small or large professional practice organizations.

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Written comments may be submitted until April 13, 1992, to Hilary H. Connor, M.D., Executive Director, Board of Medicine, 1601 Rolling Hills Dr., Richmond, VA 23229.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Dr., Richmond, VA 23229, telephone (804) 662-9925.

Credentials Committee

February 22, 1992 - 8 a.m. – Open Meeting
Department of Health Professions, Board Room 3, 1601 Rolling Hills Drive, Richmond, Virginia. ♿

A meeting to (i) conduct general board business; (ii) interview and review medical credentials of applicants applying for licensure in Virginia in open and executive session; (iii) discuss other items which may come before the committee. The Credentials Committee will entertain brief public comments at the beginning of the meeting.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Legislative Committee

† **March 13, 1992 - 10 a.m.** – Open Meeting
Department of Health Professions, Board Room 3, 1601 Rolling Hills Drive, Richmond, Virginia. ♿

A meeting to (i) discuss and develop a position on liposuction and blood testing by dentists; (ii) discuss use of diet medication and chelation therapy; (iii) develop regulations regarding advertising; and (iv) discuss other items which may come before the committee. The Legislative Committee will not entertain public comments.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

Advisory Board on Physical Therapy

March 6, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, Board Room 2, 1601 Rolling Hills Drive, Richmond, Virginia. ♿

A meeting to (i) review and respond to public comments on proposed regulations, bylaws, procedure manuals; (ii) receive reports; and (iii) discuss other items which may come before the advisory board. Public comments will be received at the pleasure of the chairperson.

Contact: Eugenia K. Dorson, Deputy Executive Director, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9925.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Alzheimer's Disease and Related Disorders Commission

† **February 24, 1992 - 1 p.m.** – Open Meeting
Lucy Corr Nursing Home, 16800 Lucy Corr Drive, Chesterfield, Virginia. ♿

A quarterly meeting to discuss special care units and legislation pertaining to Alzheimer's Disease.

Contact: Saundra Rollins, Director, Geriatric Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-1530 or SCATS (804) 371-4837.

Prevention and Promotion Advisory Council

February 13, 1992 - 10 a.m. – Open Meeting
James Madison Building, 13th Floor Conference Room, 109 Governor Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A regular meeting to (i) finalize by-laws; (ii) conduct general business; (iii) discuss an update of activities of the Prevention Office and (iv) begin plans for Phase II of the Plan for Prevention Services.

Contact: Harriet Russell, Director, Office of Prevention, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-1530 or (804) 371-8977/TDD ☎

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (STATE BOARD)

† **April 10, 1992** – 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 State Mental Health,

Mental Retardation and Substance Abuse Services Board intends to adopt regulations entitled: **VR 470-05-01. Certification of Case Management.** These regulations establish requirements which facilities must meet in order to receive reimbursement from Medicaid for Case Management Services. The regulations require that case managers meet knowledge, skills and abilities set forth in the regulations and that facilities meet the standards established by the regulations.

STATEMENT

The Department of Mental Health, Mental Retardation and Substance Abuse Services together with the Department of Medical Assistance Services has expanded Medicaid coverage to include six mental health services and two mental retardation services. The purpose of this expansion of the Medicaid program is to obtain federal financial participation for these services at a time of increasing fiscal constraints on state dollars.

Item 466.F.5 of the 1990 Appropriations Act requires that, "Qualified providers shall be licensed or certified under regulations promulgated by the Department of Mental Health, Mental Retardation and Substance Abuse Services." One of the services covered by the expanded Medicaid Program, case management, is not currently licensed by this department and therefore regulations must be promulgated to implement this requirement. These regulations require that in order for facilities to be reimbursed for case management services by Medicaid, they must employ case managers who meet knowledge, skills and abilities established by the Department of Mental Health, Mental Retardation and Substance Abuse Services. In addition, the facilities must meet other requirements set forth in the regulations.

The requirements set forth in these permanent regulations are substantially the same as the emergency regulations with some very minor revisions. Since all facilities which have expressed an interest in providing case management services have done so with no additional expenditure of funds, these regulations should have no fiscal impact.

Statutory Authority: §§ 37.1-10 and 37.1-179 et seq. of the Code of Virginia, and § I-92, Item 466.F.5 of the 1990-92 Appropriation Act.

Written comments may be submitted until April 10, 1992, to Ben Saunders, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23229.

Contact: Rubyjean Gould, Director of Administrative Services, Department of Mental Health, Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3915.

STATE MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES BOARD

† **February 26, 1992 - 10 a.m.** – Open Meeting
Central Office, James Madison Building, 109 Governor Street, Richmond, Virginia. ♿

A regular monthly meeting. The agenda will be published on February 19, and may be obtained by calling Jane V. Helfrich.

Tuesday: Informal Session - 8 p.m.

Wednesday: Committee Meetings - 9 a.m.

Wednesday: Regular Session - 10 a.m.

See agenda for location.

Contact: Jane V. Helfrich, Board Administrator, State Mental Health, Mental Retardation and Substance Abuse Services Board, P.O. Box 1797, Richmond, VA 23214, telephone (804) 786-3921.

MIDDLE VIRGINIA BOARD OF DIRECTORS AND THE MIDDLE VIRGINIA COMMUNITY CORRECTIONS RESOURCES BOARD

March 5, 1992 - 7 p.m. – Open Meeting
502 South Main Street #4, Culpeper, Virginia.

From 7 p.m. until 7:30 p.m. the Board of Directors will hold a business meeting to discuss DOC contract, budget, and other related business. Then the CCRB will meet to review cases before for eligibility to participate with the program. It will review the previous month's operation (budget and program related business).

Contact: Lisa Ann Peacock, Program Director, 502 South Main Street #4, Culpeper, VA 22701, telephone (703) 825-4562.

VIRGINIA MILITARY INSTITUTE

Board of Visitors

February 15, 1992 - 8:30 a.m. – Open Meeting
Virginia Military Institute, Smith Hall, Board Room, Lexington, Virginia. ♿

A regular meeting to (i) consider committee reports; (ii) consider 1992-1993 budget; and (iii) discuss reports on visits to academic departments.

Contact: Colonel Edwin L. Dooley, Jr., Secretary to the Board of Visitors, Virginia Military Institute, Lexington, VA 24450, telephone (703) 464-7206.

DEPARTMENT OF MINES, MINERALS AND ENERGY

Division of Mined Land Reclamation

February 11, 1992 - 1 p.m. – Open Meeting
Department of Mines, Minerals and Energy, Conference Room 116, located off U.S. Route 23 North adjacent to Mountain Empire Community College Campus, Big Stone Gap, Virginia. ♿

A meeting to give interested persons an opportunity to be heard in regard to the FY92 Abandoned Mine Land Administrative Grant Application to be submitted to the Federal Office of Surface Mining.

Contact: Roger L. Williams, Abandoned Mine Land Manager, P.O. Drawer 900, Big Stone Gap, VA 24219, telephone (703) 523-8206.

BOARDS OF NURSING AND MEDICINE

March 12, 1992 – 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 Boards of Nursing and Medicine intend to adopt regulations entitled: **VR 465-12-1 and VR 495-03-1. Regulations for Prescriptive Authority for Nurse Practitioners.** The proposed regulations authorize limited prescriptive authority for nurse practitioners as allowed by changes in law enacted during the 1991 session of the General Assembly of Virginia.

Statutory Authority: §§ 54.1-2400 and 54.1-2757.01 of the Code of Virginia.

Written comments may be submitted until March 12, 1992.

Contact: Corrine F. Dorsey, R.N., Executive Director, Board of Nursing, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9909.

PRIVATE SECURITY SERVICES ADVISORY BOARD

† **February 19, 1992 - 9:30 a.m.** – Open Meeting
LaQuinta Inn, 6910 Midlothian Turnpike, Richmond, Virginia. ♿

A meeting to discuss business of the Advisory Board.

Contact: Paula J. Scott, Staff Executive, Department of Criminal Justice Services, 805 East Broad Street, 10th Floor, Richmond, VA 23219, telephone (804) 786-4000.

BOARD OF PROFESSIONAL COUNSELORS

February 13, 1992 - 5:30 p.m. – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to (i) conduct general business; (ii) conduct regulatory review; and (iii) respond to committee reports. No public comments.

February 14, 1992 - 9 a.m. – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

An informal administrative hearing, not for public comment.

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.

Task Force on Substance Abuse

† **February 11, 1992 - Noon** – Open Meeting
Department of Health Professions, 1601 Rolling Hills Drive, Richmond, Virginia.

A meeting to conduct regulatory review and general business regarding substance abuse counselor certification. No public comments.

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.

REAL ESTATE APPRAISER BOARD

† **February 18, 1992 - 10 a.m.** – Open Meeting
Department of Commerce, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting of adopt final regulations

Contact: Demetra Kontos, Assistant Director, Department of Commerce, 3600 W. Broad Street, Richmond, VA 23230, telephone (804) 367-2175 or (804) 367-9753/TDD ☎

BOARD OF REHABILITATIVE SERVICES

February 13, 1992 - 10 a.m. – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to (i) receive department reports; (ii) consider regulatory matters; and (iii) conduct the regular business of the board.

Contact: Susan L. Urofsky, Commissioner, 4901 Fitzhugh Avenue, Richmond, VA 23230, telephone (804) 367-0319, toll-free 1-800-552-5019/TDD/Voice ☎ or (804)

367-0280/TDD ☎

Finance Committee

February 13, 1992 - 9 a.m. – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to review monthly financial reports and budgetary projections.

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 ☎

Legislation Committee

February 13, 1992 - 9 a.m. – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

General Assembly legislative update.

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 ☎

Program and Evaluation Committee

February 13, 1992 - 9 a.m. – Open Meeting
4901 Fitzhugh Avenue, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A meeting to discuss appropriate program information relative to General Assembly issues.

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 FOR RIGHTS OF VIRGINIANS WITH DISABILITIES

Protection and Advocacy for Mentally Ill Individuals Advisory Council

February 20, 1992 - 9:30 a.m. – Open Meeting
James Monroe Building, Conference Room B, 101 North 14th Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

A regular bi-monthly meeting. Time is provided for public comment.

Contact: Rebecca Currin, Department for Rights of Virginians with Disabilities, Monroe Building, 101 North 14th Street, Richmond, VA 23219, telephone (804) 225-2042 or toll-free 1-800-552-3962.

DEPARTMENT OF SOCIAL SERVICES (BOARD OF)

February 28, 1992 – 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 Social Services intends to repeal regulations entitled: **VR 615-25-01. Minimum Standards for Licensed Family Day Care Homes.** The existing regulation, Minimum Standards for Licensed Family Day Care Homes, is proposed for repeal while concurrently promulgating Minimum Standards for Licensed Group Family Day Care Homes.

Statutory Authority: § 63.1-202 of the Code of Virginia.

Written comments may be submitted until February 28, 1992.

Contact: Peggy Friedenberg, Legislative Analyst, Office of Governmental Affairs, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

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February 28, 1992 – 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 Social Services intends to adopt regulations entitled: **VR 615-25-01:1. Minimum Standards for Licensed Group Family Day Care Homes.** The proposed regulation makes major additions and revisions in the licensing standards caused by changes in the Code of Virginia relating to a group family day care homes and deemed necessary to update licensing requirements which have not been significantly revised since 1979.

Statutory Authority: § 63.1-202 of the Code of Virginia.

Written comments may be submitted until February 28, 1992.

Contact: Peggy Friedenberg, Legislative Analyst, Office of Governmental Affairs, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

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† **April 10, 1992** – 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 Social

Services intends to amend regulations entitled: **VR 615-70-17. Child Support Enforcement Program.** The proposed amendments address four areas: (i) administrative deviation from the child support guideline/multiple family situations; (ii) default obligations; (iii) release of information to the public; and (iv) technical items.

STATEMENT

Basis: The proposed revisions to the child support regulation are the result of recommendations of work groups which looked at issues related to administrative deviation from the child support guideline, default obligation, release of information, and the department's new automated system.

Purpose: The proposed revisions are intended to improve the child support regulation by addressing and clarifying issues which have impeded the effectiveness of the child support program.

Substance: The revisions are in four broad areas. The first revision would allow administrative deviation from the child support guideline by allowing the Department of Social Services to consider multiple families when administratively calculating the child support obligation owed. The second revision would allow the department to use median income data in calculating an administrative obligation when the absent parent does not provide financial information. The third revision would allow the department to release financial information to the other parent. The fourth revision clarifies the terminology related to medical support services, absent responsible parent, and debt and arrearages.

Impact: It is anticipated that the number of administrative hearing decisions and those that are further appealed to court will decrease. It is also anticipated that the number of support orders established based on the absent parent's ability to pay will increase using higher default obligation amounts. More absent parents are expected to bring in their financial statements due to higher obligations that will be established by the new default obligation process. The release of information should be clearer to both the department's staff as well as for the absent and custodial parents. Terminology that is clearer should also enable those who use the department's child support services to better understand the handling of child support cases.

Statutory Authority: §§ 63.1-25 and 63.1-249 through 63.1-274.10 of the Code of Virginia.

Written comments may be submitted until April 10, 1992, to Penelope Boyd Pellow, Division of Child Support Enforcement, 8007 Discovery Drive, Richmond, VA 23229-8699.

Contact: Margaret J. Friedenberg, Legislative Analyst, Office of Governmental Affairs, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229-8699, telephone (804) 662-9217.

STATE BOARD OF SOCIAL SERVICES

February 19, 1992 - 2 p.m. – Open Meeting
February 20, 1992 - if necessary - 9 a.m. – Open Meeting
Department of Social Services, 8007 Discovery Drive, Richmond, Virginia. ♿

Work session and formal business meeting of the board.

Contact: Phyllis Sisk, Staff Specialist, Department of Social Services, 8007 Discovery Drive, Richmond, VA 23229, telephone (804) 662-9236, toll-free 1-800-552-3431 or 1-800-552-7096/TDD ☎

COMMONWEALTH TRANSPORTATION BOARD

February 19, 1992 - 2 p.m. – Open Meeting
Virginia Department of Transportation, Board Room, 1401 East Broad Street, Richmond, Virginia. ♿ (Interpreter for deaf provided upon request)

Work session of the Commonwealth Transportation Board and the Department of Transportation staff.

February 20, 1992 - 10 a.m. – Open Meeting
Virginia Department of Transportation, Board Room, 1401 East 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, 1491 East Broad Street, Richmond, VA 23219, telephone (804) 786-6670.

DEPARTMENT OF TRANSPORTATION (COMMONWEALTH TRANSPORTATION BOARD)

† **April 13, 1992 - 9:30 a.m.** – Public Hearing
Front Auditorium, Old Highway Building, 1221 East Broad Street, Richmond, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the Commonwealth

Transportation Board intends to amend regulations entitled: **VR 385-01-09. Public Participation Guidelines.** The Administrative Process Act (§ 9-6.14:1 et seq.) of the Code of Virginia requires the Department of Transportation to establish guidelines under which input from the public can be gathered during the adoption of regulations subject to the Act. The amendments to the Public Participation Guidelines update references in the text which are no longer correct.

The amendments also change the requirement that a 60-day time period must elapse between notice of the public hearing and a public hearing. As proposed, the 60-day period would extend from the date of public notice to the last date given in the notice for submission of any written comment, which is the requirement of the Act itself. This change was made to reduce the amount of time before a regulation becomes effective, thereby streamlining the process.

STATEMENT

Substance, Issues, Basis, Purpose, and Estimated Impact: The substance of the regulations deals with the requirements each agency must implement to seek input concerning proposed regulations as directed by § 9-6.14:7.1 of the Administrative Process Act.

The issues raised by these regulations pertain to the process by which the department will inform specific parties, as well as the citizens of the Commonwealth at large, of the enactment or amendment of those regulations covered by the Administrative Process Act.

The basis for the regulations are contained in § 33.1-12 and § 9-6.14:1 et seq. of the Code of Virginia. The former section gives the Commonwealth Transportation Board the power to issue regulations generally, while the latter section deals specifically with the provisions of the Administrative Process Act itself.

The purpose of the regulations is to provide a process whereby the public may be allowed the opportunity to provide input to the department concerning the promulgation of regulations covered by the Administrative Process Act. The amendments are necessary to correct obsolete nomenclature, and to bring the guidelines up to date with current interpretations of the Act's public participation requirements.

The estimated impact of the amendments will be nonexistent in financial terms, since essential elements of the public participation process, such as the notification process, remain unchanged. The primary effects of the regulations will be to remove obsolete references in the text, and eliminate some of the time requirements contained in the current regulations. As a result, the process will be streamlined.

Statutory Authority: §§ 33.1-12 and 9.6-14:1 et seq. of the Code of Virginia.

Written comments may be submitted until April 20, 1992, to Larry D. Jones, Management Services Division, Room 712, Highway Annex, Virginia Department of Transportation, 1401 E. Broad Street, Richmond, VA 23219.

Contact: David L. Roberts, Management Lead Analyst, Management Services Division, Room 712, Highway Annex, Virginia Department of Transportation, 1401 E. Broad Street, Richmond, VA 23219, telephone (804) 786-3620.

TREASURY BOARD

† **February 19, 1992 - 9 a.m.** – Open Meeting
† **March 18, 1992 - 9 a.m.** – Open Meeting
James Monroe Building, 101 North 14th Street, 3rd floor, Treasury Board Conference Room, Richmond, Virginia.

A regular meeting.

Contact: Belinda Blanchard, Assistant Investment Officer, Department of the Treasury, P.O. Box 6-H, Richmond, VA 23215, telephone (804) 225-2142.

BOARD OF VETERINARY MEDICINE

February 12, 1992 - 8:30 a.m. – Open Meeting
Ritz Carlton Tysons Corner, Plaza Room, 1700 Tysons Boulevard, McLean, Virginia. (Interpreter for deaf provided upon request)

A general board and business meeting.

Contact: Terri H. Behr, Executive Secretary, 1601 Rolling Hills Drive, Richmond, VA 23229, telephone (804) 662-9915 or 1-800-533-1560.

UNIVERSITY OF VIRGINIA

Institute of Law, Psychiatry and Public Policy

March 12, 1992 - 9 a.m. – Open Meeting
March 13, 1992 - 9 a.m. – Open Meeting
Richmond Hyatt Hotel, Richmond, Virginia.

Fifteenth annual symposium on mental health law issues including: (i) patient self-determination act; (ii) substance abuse and AIDS; (iii) management of care; (iv) child sexual abuse - changes in the statute of limitations; (v) satanism and ritualistic crime; (vi) workshops on civil commitment, ethical concerns regarding incompetent assent; and (vii) Americans with Disabilities Act.

Contact: Carolyn L. Engelhard, Administrator, Institute of Law, Psychiatry and Public Policy, University of Virginia, Box 100, Blue Ridge Hospital, Charlottesville, VA 22901,

telephone (804) 924-5435 or (804) 924-HEAR/TDD ☎

VIRGINIA RACING COMMISSION

February 19, 1992 - 9:30 a.m. – Open Meeting
VSRS Building, 1200 East Main Street, Richmond, Virginia. ♿

A regular meeting including discussion and public participation on drafts of proposed regulations pertaining to the Virginia Breeders Fund and medication.

† **March 18, 1992 - 9:30 a.m.** – Open Meeting
VSRS Building, 1200 East Main Street, Richmond, Virginia. ♿

A regular meeting including discussion of proposed regulations pertaining to the Virginia Breeders Fund and medication. There will be an opportunity for public participation.

Contact: William H. Anderson, Policy Analyst, Virginia Racing Commission, P.O. Box 1123, Richmond, VA 23208, telephone (804) 371-7363.

VIRGINIA RESOURCES AUTHORITY

February 11, 1992 - 9 a.m. – Open Meeting
March 10, 1992 - 9 a.m. – Open Meeting
The Mutual Building, 909 East Main Street, Suite 707, Conference Room A, Richmond, Virginia.

The board will meet to (i) approve minutes of its previous meeting; (ii) review the Authority's operations for the prior months; and (iii) consider other matters and take other actions as it may deem appropriate. The planned agenda of the meeting will be available at the offices of the Authority one week prior to the date of the meeting.

Public comments will be received at the beginning of the meeting.

Contact: Mr. Shockley D. Gardner, Jr., 909 East Main Street, Suite 707, Mutual Building, Richmond, VA 23219, telephone (804) 644-3100 or FAX number (804) 644-3109.

VIRGINIA COUNCIL ON VOCATIONAL EDUCATION

February 25, 1992 - 1 p.m. – Open Meeting
Sheraton Airport Inn, 4700 South Laburnum Avenue, Richmond, Virginia.

1 p.m. - Committee Meetings
2 p.m. - General Session
3 p.m. - Work Session

February 26, 1992 - time and location to be announced – Open Meeting

Meeting with Virginia Board of Education.

Contact: George S. Orr, Jr., Virginia Council on Vocational Education, 7420-A Whitepine Road, Richmond, VA 23237, telephone (804) 275-6218.

VIRGINIA VOLUNTARY FORMULARY BOARD

† **March 18, 1992 - 10 a.m.** – Public Hearing
109 Governor Street, Main Floor Conference Room, Richmond, Virginia.

A public hearing 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 February 15, 1991, 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 March 18, 1992, will be made a part of the hearing record.

Contact: James K. Thomson, Director, Bureau of Pharmacy Services, 109 Governor Street, Room B1-9, Richmond, VA 23219, telephone (804) 786-4236.

DEPARTMENT OF WASTE MANAGEMENT (VIRGINIA WASTE MANAGEMENT BOARD)

February 24, 1992 - 10 a.m. – Public Hearing
101 North 14th Street, Conference Room C, Richmond, Virginia.

February 26, 1992 - 1 p.m. – Public Hearing
Room 2123, Amherst Building, Central Virginia Community College, Lynchburg, 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 adopt regulations entitled: **VR 672-20-11. Solid Waste Management Facility Permit Application Fees.** The purpose of the proposed regulation is to establish schedules and procedures pertaining to the payment and collection of fees from any applicant seeking a new permit or seeking an amendment to an existing permit for operation of a solid or infectious waste management facility in the Commonwealth.

Statutory Authority: § 10.1-1402 of the Code of Virginia.

Written comments may be submitted until March 1, 1992.

Contact: W. Gulevich, 101 N. 14th Street, Richmond, Virginia 23219, telephone (804) 371-2383.

February 27, 1992 - 7:30 p.m. – Public Hearing
Charles City County Community Neighborhood Center, Neighborhood Facility Building located in Courthouse Complex, 10600 Courthouse Road, Charles City, Virginia.

Pursuant to the requirements of Part VII of the Virginia Solid Waste Management Regulations (Permitting of Solid Waste Management Facilities), the Department of Waste Management will hold a public hearing on the draft permit amendments proposed by Chambers, Inc., on behalf of Charles City County for a vertical expansion of the landfill, design, operational and closure plan changes.

The public comment period will extend until March 9 at 5 p.m. A copy of the proposed draft permit amendments may be obtained from Russell McAvoy Jr., Department of Waste Management, Sixth Floor, Monroe Building, 101 North 14th Street, Richmond, VA 23219.

Contact: Hassan Vakili, Environmental Technical Services Administrator, Virginia Department of Waste Management, Sixth Floor, Monroe Building, 101 N. 14th Street, Richmond, Virginia 23219, telephone (804) 371-0519 or toll-free 1-800-552-2075.

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February 28, 1992 - 11 a.m. – Public Hearing
Virginia Department of Waste Management, 11th Floor, Monroe Building, 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 Virginia Waste Management Board intends to amend regulations entitled: **VR 672-30-1. Virginia Regulations Governing the Transportation of Hazardous Materials.** The purpose of the proposed amendments is to incorporate by reference changes that were made by U.S. DOT to Title 49, Code of Federal Regulations from July 1, 1990, to June 30, 1991.

Statutory Authority: §§ 10.1-1402 and 10.1-1450 of the Code of Virginia.

Written comments may be submitted until February 28, 1992, to John E. Fly, Virginia Department of Waste Management, 11th Floor, Monroe Building, Richmond, Virginia 23219.

Contact: C. Ronald Smith, Hazardous Waste Enf. Chief, Virginia Department of Waste Management, 11th Floor, Monroe Building, 101 N. 14th Street, Richmond, Virginia 23219, telephone (804) 225-4761 or toll-free 1-800-552-2075.

STATE WATER CONTROL BOARD

February 17, 1992 – 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 State Water Control Board intends to adopt regulations entitled: **VR 680-15-02. Virginia Water Protection Permit Regulation.** The proposed regulation delineates the procedures and requirements to be followed for issuance of a Virginia Water Protection Permit. An informal question and answer period has been scheduled before each hearing. At that time, staff will answer questions from the public on the proposal. The questions and answer period will begin at 6:30 p.m. on the same day and at the same location as the public hearings.

Statutory Authority: § 62.1-44.15:5 of the Code of Virginia.

Written comments may be submitted until 4 p.m., February 17, 1992, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Martin Ferguson, Office of Water Resources Management, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5030.

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February 10, 1992 - 7 p.m. – Public Hearing
Harrisonburg City Council Chambers, 345 South Main Street, Harrisonburg, Virginia. 7

February 12, 1992 - 7 p.m. – Public Hearing
University of Virginia, Southwest Center, Classroom 1 and 2, Highway 19 North, Abingdon, Virginia.

February 13, 1992 - 2 p.m. – Public Hearing
Lynchburg Public Library, Community Meeting Room, 2315 Memorial Avenue, Lynchburg, Virginia.

February 19, 1992 - 7 p.m. – Public Hearing
James City County, Board of Supervisors Room, 101C Mounts Bay Road, Williamsburg, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to amend regulations entitled: **VR 680-21-00. Water Quality Standards.** The purpose of the proposal is to adopt, for statewide application, standards for toxics for protection of aquatic life and human health to comply with the Clean Water Act. The board will hold a formal hearing at a time and place to be established, if a petition for such a hearing is received and granted. Affected persons may petition for a formal hearing concerning any issue of fact directly relevent to the legal validity of the proposed action. Petitions must meet the requirements

of § 1.23(b) of the board's Procedural Rule No. 1 (1980), and must be received by the contact person designated below by 4 p.m. on Thursday, January 30, 1992.

Statutory Authority: § 62.1-44.15(3a) of the Code of Virginia.

Written comments may be submitted until 4 p.m., March 2, 1992, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Jean Gregory, Office of Environmental Research and Standards, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5093.

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February 10, 1992 - 7 p.m. – Public Hearing
Harrisonburg City Council Chambers, 345 South Main Street, Harrisonburg, Virginia.

February 14, 1992 - 2 p.m. – Public Hearing
State Water Control Board, Board Room, 4900 Cox Road, Innsbrook Corporate Center, Glen Allen, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to adopt regulations entitled: **VR 680-14-09. Virginia Pollutant Discharge Elimination System (VPDES) General Permit for Domestic Sewage Discharges of Less Than or Equal to 1,000 Gallons Per Day.** The purpose of the proposal is to adopt as a permanent regulation the emergency regulation which became effective July 12, 1991, authorizing the issuance of a general permit for qualifying domestic sewage discharges of less than or equal to 1,000 gallons per day.

Statutory Authority: § 62.1-44.15(10) of the Code of Virginia.

Written comments may be submitted until 4 p.m., March 2, 1992, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Richard Ayers, Office of Water Resources Management, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5059.

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February 12, 1992 - 2 p.m. – Public Hearing
Russel County Circuit Court Room, Main Street, Lebanon, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to amend regulations entitled: **VR 680-21-00. Water Quality Standards (VR 680-21-08.15 Tennessee and Big Sandy River Basin, Clinch River Subbasin and VR 680-21-07.1 Special Standards and Requirements.** The purpose of the proposed amendment is to establish a site-specific numerical water quality criterion for copper in the Clinch River between Carbo and St. Paul. The board will hold a formal hearing at a time and place to be determined, if a petition for such a hearing is received and granted. Affected persons may petition for a formal hearing concerning any issue of fact directly relevant to the legal validity of the proposed action. Petitions must meet the requirements of § 1.23(b) of the board's Procedural Rule No. 1 (1980), and must be received by the contact person designated below by 4 p.m on Thursday, January 30, 1992.

Statutory Authority: § 62.1-44.15(3a) of the Code of Virginia.

Written comments may be submitted until 4 p.m., March 2, 1992, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Jean Gregory, Office of Environmental Research and Standards, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5093.

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February 26, 1992 - 7 p.m. – Public Hearing
Harrisonburg City Council Chambers, 345 South Main Street, Harrisonburg, Virginia.

February 27, 1992 - 2 p.m. – Public Hearing
Municipal Office, Multi-Purpose Room, 150 East Monroe Street, Wytheville, Virginia.

March 2, 1992 - 7 p.m. – Public Hearing
Prince William County Boardroom, 1 County Complex, McCourt Building, Prince William, Virginia.

March 4, 1992 - 7 p.m. – Public Hearing
James City County, Board of Supervisors Room, Building C, 101C Mounts Bay Road, Williamsburg, Virginia.

† **March 9, 1992 - 7 p.m.** – Public Hearing
South Boston City Council Chambers, Yancey Street (behind the library), South Boston, Virginia.

† **March 10, 1992 - 7 p.m.** – Public Hearing
Northampton General District Court, Business Route 13, Eastville, Virginia.

Notice is hereby given in accordance with § 9-6.14:7.1 of the Code of Virginia that the State Water Control Board intends to adopt regulations entitled: **VR 680-15-03. Surface Water Management Area Regulation.** The purpose of the proposed regulation is to establish the procedures and requirements to be followed in connection with establishment of surface water management areas, and the issuance of surface water withdrawal permits and certificates.

Statutory Authority: Chapter 25 (§ 62.1-242 et seq.) of Title 62.1 of the Code of Virginia.

Written comments may be submitted until 4 p.m., March 16, 1992, to Doneva Dalton, Hearing Reporter, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230.

Contact: Thomas Felvey, State Water Control Board, P.O. Box 11143, Richmond, Virginia 23230, telephone (804) 527-5092.

LEGISLATIVE

Notice to Subscribers

Legislative meetings held during the Session of the General Assembly are exempt from publication in The Virginia Register of Regulations. You may call Legislative Information for information on standing committee meetings. The number is (804) 786-6530.

CHRONOLOGICAL LIST

OPEN MEETINGS

February 10
Barbers, Board for
Chesapeake Bay Local Assistance Board
- Central Area Review Committee

February 11
Architects, Land Surveyors, Professional Engineers and Landscape Architects, Board for
- Board for Professional Engineers
Higher Education for Virginia, State Council on
Mines, Minerals and Energy, Department of
- Division of Mined Land Reclamation
† Professional Counselors, Board of
- Task Force on Substance Abuse
Virginia Resources Authority

February 12
Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
† Child Day-Care Council
Conservation and Recreation, Department of
- Uppper James Scenic River Advisory Board
Corrections, Board of
Veterinary Medicine, Board of

February 13
Agriculture and Consumer Services, Department of
- Virginia Cattle Industry Board
† Child Day-Care Council
Corrections, Board of
- Liaison Committee
Geology, Board for
Mental Health, Mental Retardation and Substance Abuse Services, Department of
- Prevention and Promotion Council
Professional Counselors, Board of
Rehabilitative Services, Board of
- Finance Committee
- Legislation Committee
- Program and Evaluation Committee

February 14
† General Services, Department of
- Forensic Science Advisory Board
Geology, Board for
Long-Term Care Council
Professional Counselors, Board of

February 15
Military Institute, Virginia
- Board of Visitors

February 18
Historic Resources, Department of
- State Review Board
† Housing Development Authority, Virginia
† Real Estate Appraiser Board

February 19
Alcoholic Beverage Control Board
Chesapeake Bay Local Assistance Board
- Regulatory Review Committee and Program Study Group
- Southern Area Review Committee
† Child Day-Care Council
Historic Resources, Board of
† Local Debt, State Council on
† Private Security Services Advisory Board
Social Services, State Board of
Commonwealth Transportation Board
† Treasury Board
Virginia Racing Commission

February 20
† Agriculture and Consumer Services, Department of
- Virginia Apple Board
- Virginia Corn Board
† Fire Services Board, Virginia
- Fire Prevention and Control Committee
- Fire Training/EMS Education Committee
- Legislative/Liaison Committee
Labor and Industry, Department of
- Virginia Apprenticeship Council
Rights of Virginians with Disabilities, Department for
- Protection and Advocacy for Mentally Ill Individuals Advisory Council
Commonwealth Transportation Board

February 21
† Agriculture and Consumer Services, Department of
- Virginia Bright Flue-Cured Tobacco
- Virginia Corn Board
† Children, Interdepartmental Regulation of Residential Facilities for

- Coordinating Committee
Conservation and Recreation, Department of
- Falls of the James Scenic River Advisory Board
† Fire Services Board, Virginia

February 22
Medicine, Board of
- Credentials Committee

February 24
Chesapeake Bay Local Assistance Board
- Central Area Review Committee
Commerce, Board of
† Education Loan Authority, Virginia
- Board of Directors
Lottery Department, State
† Mental Health, Mental Retardation and Substance Abuse Services, Department of
- Alzheimer's Disease and Related Disorders Commission

February 25
† ASAP Policy Board - Rockbridge
- Board of Directors
Health Services Cost Review Council, Virginia
† Labor and Industry, Department of
- Safety and Health Codes Board
Marine Resources Commission
† Mental Health, Mental Retardation and Substance Abuse Services Board, State
Vocational Education, Virginia Council

February 26
† Agriculture and Consumer Services, Board of
Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
† Child Day-Care Council
† Mental Health, Mental Retardation and Substance Abuse Services Board, State
Vocational Education, Virginia Council

February 27
† Agriculture and Consumer Services, Board of
Chesapeake Bay Local Assistance Board
Compensation Board
† Contractors, Board for
- Complaints Committee

February 28
† Building Code Technical Review Board, State

March 2
Alcoholic Beverage Control Board

March 4
Chesapeake Bay Local Assistance Board
- Southern Area Review Committee
† Child Day-Care Council

March 5
† Housing and Community Development, Board of
- Amusement Device Technical Advisory Committee
Middle Virginia Board of Directors and the Middle Virginia Community Corrections Resources Board

March 6
† Game and Inland Fisheries, Board of
Medicine, Board of
- Advisory Board on Physical Therapy

March 7
† Game and Inland Fisheries, Board of

March 9
Chesapeake Bay Local Assistance Board
- Central Area Review Committee

March 10
Virginia Resources Authority

March 11
Agriculture and Consumer Services, Department of
- Virginia Sweet Potato Board
Chesapeake Bay Local Assistance Board
- Northern Area Review Committee
† Child Day-Care Council
† Corrections, Board of
Emergency Planning Committee, Local - City of Portsmouth
Historic Preservation Foundation, Virginia

March 12
† Corrections, Board of
- Liaison Committee
University of Virginia
- Institute of Law, Psychiatry and Public Policy

March 13
† Medicine, Board of
- Legislative Committee
University of Virginia
- Institute of Law, Psychiatry and Public Policy

March 16
Alcoholic Beverage Control Board
† Health, Department of
- Division of Shellfish Sanitation

March 17
Library Board

March 18
Chesapeake Bay Local Assistance Board
- Regulatory Review Committee and Program Study Group
- Southern Area Review Committee
† Local Debt, State Council on
† Treasury Board
† Virginia Racing Commission

March 20
† Children, Interdepartmental Regulation of Residential

Facilities for
- Coordinating Committee

March 23
Chesapeake Bay Local Assistance Board
- Central Area Review Committee

March 25
Chesapeake Bay Local Assistance Board
- Northern Area Review Committee

March 26
Chesapeake Bay Local Assistance Board
Compensation Board

March 30
Alcoholic Beverage Control Board

April 2
Emergency Planning Committee, Local - Chesterfield County

April 6
† Agriculture and Consumer Services, Department of
- Virginia Winegrowers Advisory Board

PUBLIC HEARINGS

February 10
Health, Department of
Water Control Board, State

February 11
Emergency Planning Committee, Local - Cities of Hampton, Newport News, Williamsburg and Poquoson and the County of York

February 12
Corrections, Department of
Water Control Board, State

February 13
Water Control Board, State

February 14
Water Control Board, State

February 19
† Contractors, Board for
Health, Department of
Water Control Board, State

February 24
Waste Management, Department of

February 26
Waste Management, Department of
Water Control Board, State

February 27
Waste Management, Department of
Water Control Board, State

February 28
Waste Management, Department of

March 2
Water Control Board, State

March 4
Water Control Board, State

March 6
Criminal Justice Services, Department of

March 9
† Water Control Board, State

March 10
† Water Control Board, State

March 18
† Voluntary Formulary Board, Virginia

April 1
Criminal Justice Services, Department of

April 13
† Transportation, Department of